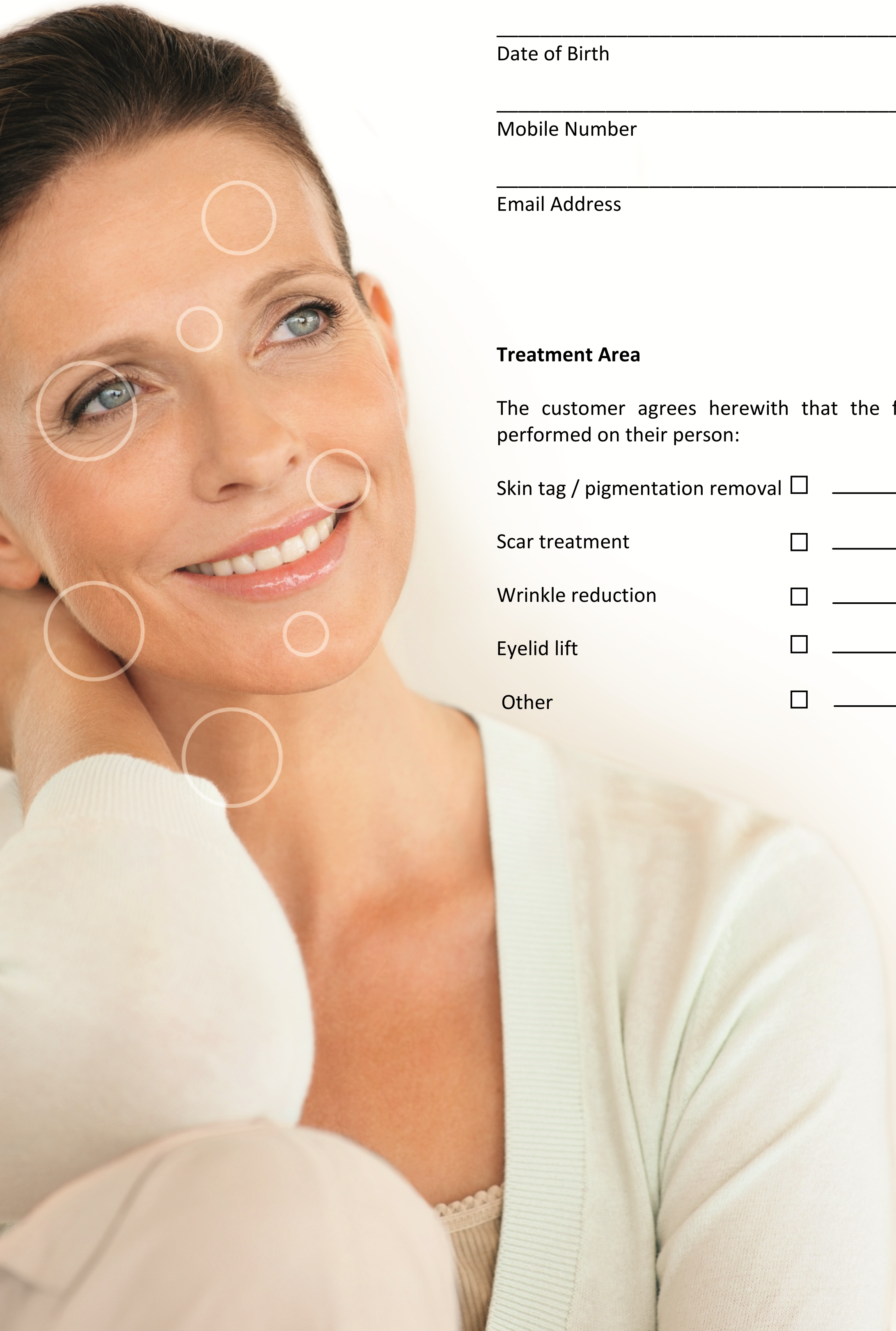
Client Evaluation and Release



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First name and Surname

____
Street address

____
Area / Postal Code

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Date of Birth

____
Mobile Number

____
Email Address

Treatment Area

The customer agrees herewith that the following treatment/s may be performed on their person:

Skin tag / pigmentation removal ☐ ______________________________

Scar treatment ☐ ______________________________

Wrinkle reduction ☐ ______________________________

Eyelid lift ☐ ______________________________

Other ☐ ______________________________

2. Medical History – This information will be treated confidentially			
Have you had any filler injections within the last 2 months?	Yes/**No**	Do you take any Anti-acne medication (Roaccutane, Isotretinoin, Vitamin A acid etc.)?	Yes/**No**
Have you had any acid peelings? If so when?	Yes/**No**	Do you suffer from cancer?	Yes/**No**
Have you had a thread lifting or Botox injection? If so when?	Yes/**No**	Do you suffer from an Autoimmune disease?	Yes/**No**
Have you had an ablative laser treatment? If so when?	Yes/**No**	Do you suffer from Herpes Simplex (Cold Sores)?	Yes/**No**
Have you experienced problems with numbing injections e.g. at the Dentist?	Yes/**No**	Do you have a fever / infectious disease	Yes/**No**
Do you have any metal implants in your body?	Yes/**No**	Do you suffer from Epilepsy?	Yes/**No**
Are you pregnant or breastfeeding?	Yes/**No**	Do you have acute heart disease or blood pressure problems?	Yes/**No**
Do you suffer from Haemophilia? (bleeding disorder)	Yes/**No**	Do you take blood thinning medication?	Yes/**No**
Do you suffer from Diabetes?	Yes/**No**	Do you have a pacemaker?	Yes/**No**
Are you HIV-Positive?	Yes/**No**	Do you suffer from Keloid development?	Yes/**No**
Do you suffer from Hepatitis A, B, C, D, E, F?	Yes/**No**	In the last 24 hours, have you taken drugs, aspirin or drank alcohol?	Yes/**No**
Do you suffer with Alcoholism?	Yes/**No**	Do you regularly take St John's Wort, pineapple, kiwi	Yes/**No**
Do you suffer from an auto immune skin condition? e.g. Psoriasis, Eczema.	Yes/**No**	In the last 14 days have you had an operation or radiation therapy?	Yes/**No**
Have you had Cortisone (cream or tablets) within the last 6 months?	Yes/**No**	In the 14 days have you been treated by a doctor?	Yes/**No**
Do you have any allergies? (incl. heat allergy)	Yes/**No**	Are you on regular medication?	Yes/**No**

Additional agreements

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I herewith give permission for photos and/or videos of my treatment to be made and stored by my AICICIOIR Practitioner as confidential material. Yes ☐ No ☐	I herewith give permission for photos and/or videos of my treatment to be used for marketing purposes Yes ☐ No ☐

Treatment Information

The AICICIOIR Cosmetic Corrector is a cosmetic device and is not meant for the treatment of disease or medical ailments.

Only benign skin mutations may be removed for aesthetical reasons. The AICICIOIR practitioner may not be in a position to make a diagnosis regarding the benignity of a skin mutation. All removals may only be done after a skin specialist has made an official diagnosis declaring the benignity of said skin mutation. When removing benign skin mutations, there is a minor risk of hypertrophic/atrophic scarring, as well as hyper/hypo-pigmentation (lighter or darker skin coloration.)

Please be aware that certain benign skin mutations may return after being treated. In the unlikely case that a skin mutation previously diagnosed as benign, becomes red, inflamed, or breaks open, a diagnosis from a skin specialist must be obtained, who may in turn, remove the lesion surgically.

Treatments with the AICICIOIR Cosmetic Corrector may result in certain reactions e.g. redness and swelling. Should these symptoms persist for longer than 6 days, or should other symptoms present, please contact the AICICIOIR practitioner who treated you or your local doctor.

The number of treatments necessary to obtain the desired result, depends on the type of treatment and the size of area treated. The minimum period between treatments is 8 – 12 weeks. Your AICICIOIR practitioner may extend this period depending on your individual reaction to the treatment and your skin type accordingly.

To reduce the risk of unwanted side effects, it is imperative that the Aftercare Instructions are followed implicitly.

The risk of hyper-pigmentation is very low, but cannot be avoided. This is a normal skin reaction which usually disappears within a few months. This risk is reduced exponentially if you follow the Aftercare Instructions and avoid sun exposure, or use a sun cream with the highest SPF.

Following the treatment, please avoid extreme sun exposure, UV-light and extreme minus temperatures for 2 weeks. Please do not use the sauna, or steam room for 3 days.

In spite of all due care required, injuries can occur during the plasma treatment. In rare situations and despite using the most modern techniques, allergic reactions are possible. The Customer is aware of this possibility and takes sole responsibility.

All follow-up treatments may only be performed 12 weeks after the initial treatment. This is due to the healing and tightening process lasting 3 months. Further treatments, subject to charge, may be necessary before the desired effect is obtained.

Client Release

I certify that I have answered the medical questionnaire fully and accurately and I ……………………………… having been advised by…………………………………… completely understand all of the above information and the implications of the treatment that I will be receiving, including the listed side-effects. I can confirm that all of my questions were answered fully and understandably and that I have not been misled or badly informed by the above named therapist or clinic. I am aware that any falsification of information submitted by myself could be detrimental to my health and the success of my treatment and that the therapist or clinic will not be held liable. I have been advised that I may experience discomfort during the treatment. I hereby authorise and direct the therapist and clinic to administer the prescribed process and perform such procedures as may be deemed necessary or advisable. My signature below constitutes my acknowledgement that (1.) I have read, understood and fully agree with the aforementioned and I have received the AICICIOIR aftercare information document. (2.) I give consent to the proposed treatment process that has been satisfactorily explained to me and I have all the information I require. (3.) I hereby give my consent and authorisation voluntarily and release the establishment and its agents of any claims that I have or may have in the future in connection with the described treatment.

Signed: ………………………………………………. Date: ……………………………………………

Print Name: ……………………………………………

Practitioner: …………………………………………… Business Name : …………………………………………..

Post-Treatment Agreement

CUSTOMER'S ACCEPTANCE OF TREATMENT

I have examined the results of the treatment closely and declare said results to be in proper order and condition.

____________________ ______________________________________

Date Signature Customer

CUSTOMER'S UNDERSTANDING OF THE IMPORTANCE OF AFTERCARE

I have been given and understand, instruction in essential aftercare and have been given AICICIOIR 'Cover Care Cream' which I understand must be used as instructed to protect the treated area and aid healing.

____________________ ______________________________________

Date Signature Customer