



## Harmony Skin Rejuvenation (IPL/Photofacial) Consent

Treatment sites: \_\_\_\_\_

I \_\_\_\_\_ duly authorize Spa in the City Lasers to perform the Harmony Skin Rejuvenation procedure.

I understand that the Harmony is a device used for skin rejuvenation and that clinical results may vary in different skin types. I understand there is a possibility of short-term effects such as reddening, blistering, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me \_\_\_\_\_ (patient's initials)

Clinical results may vary depending on individual factors, including medical history, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment.

I understand that treatment by the Harmony Skin Rejuvenation system involves a series of treatments and the fee structure has been fully explained to me \_\_\_\_\_ (patient's initials)

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I am not pregnant at this time, and that I have not taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

**Blindness and eye damage** – The laser, without protective eyewear, may cause visual loss including blindness. ***It is important to keep these shields on at all times*** during the procedure and that I ***should keep my eyes closed*** in order to protect my eyes from accidental laser exposure

I understand the procedure and risks, and accept the risks, and request that this procedure be performed on me by the doctor or other qualified staff.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_



## PhotoFacial Aftercare

Following treatment your skin may feel like it has slight sunburn. You may experience erythema (redness), edema (swelling), and some discomfort of the treated areas for several hours or up to 3 days post-treatment. You may experience some purpura (purplish spots or patches) in treated areas, which would be expected to resolve within several days. If you experience itching after treatment, you may use over the counter topical hydrocortisone cream.

After treatment, your skin may appear slightly reddened which subsides rather quickly. Mild swelling may occur. You may use cold or ice packs, 10-minute intervals, as needed for comfort and to relieve swelling. Should swelling occur, application of an ice pack (10 minutes on, 10 minutes off) multiple times in the first 24 hours will help minimize the swelling.

### **Do not wash your face until the morning following the treatment.**

Use a mild cleanser (such as Cetephil or **Vivite Hydrating Wash**) and a mild moisturizer (**Vivite Hydrating Cream or Rejuvi Super Soothing Lotion/Ointment**).

If desired, you may use makeup the next day on the treated area, as long as the skin is not broken, blistered, or irritated.

Avoid hot baths or showers, aerobic exercise or massage on the treated area for 48 hours following treatment. Avoid air travel for 24 hours after treatment.

Avoid sun exposure to the treated area for 1 to 2 months following the treatment. Use a broad spectrum of sunblock of at least SPF 25 or higher at all times. (**Rejuvi Facial Sunblock** with zinc oxide is available in the office for purchase) Tanning after treatment sessions may enhance melanin regeneration, which may result in hyper-pigmentation or other side effects. We also recommend **Vivite Vibrance Therapy** to keep melanin suppressed after treatment.

Immediately after treatment you may experience any, all or none of the described symptoms from the chemical peel that was applied to your skin. Obvious flaking may or may not occur depending on the amount of build-up of oils, keratin layers and individual skin thickness. If you do see some flaking, it will not be in an even, uniform pattern and may appear in patches. Everyone is different and every treatment is different.

*Do not use **Retin A** or any other **tretinoin** or acid products on the face for the first week following peels. Do not use a washcloth, scrubs or exfoliants, Clarisonic brush or beaded washes. Blot dry with a towel....do not rub! Do not wax, laser or have electrolysis performed on the treated areas for one week post treatment. You may use our Rejuvi Soothing Lotion alone or in addition to your moisturizer. Vivite Hydrating Wash or Cetaphil is an acceptable cleanser. For severe redness you may use over the counter topical hydrocortisone cream.*

Flaking may occur in 2 to 7 days. Dry patches will occur. The fibroblasts in the cell layers have been stimulated to increase collagen production whether you have visible flaking or not.

- **Morning after treatment:** A red or pink “scrubbed” look, sensitivity to the sun or a sunburned feel to the skin may appear. Use a gentle cleanser (Vivite Hydrating Wash) and moisturizer (Vivite Hydrating Cream) and a sunscreen with a SPF 25 or higher. (Rejuvi Sunscreen with zinc oxide and titanium dioxide)
- **Day Two:** Tightness, drying and a “drawn” look may appear. Today is not the day to examine the skin for fine lines and wrinkles. Use a gentle cleanser, lots of moisturizer and a sunscreen with a SPF 25 or higher
- **Day Three thru Day Seven:** Exfoliation will occur (mild, hardly visible peeling to heavy continuous peeling, depending on your skin). Continue use of mild cleanser, moisturizer and sunscreen. Do not pick or prematurely peel the skin. This may cause scarring and irritation. You must wear a sunscreen daily!!
- **After Day Seven:** You may resume your normal skin care regimen.

Rarely, a small blister or scab may form. If this occurs, call Spa in the City (972) 998-6484. While waiting for a reply, perform gentle washing and apply antibiotic ointment (Bactracin, Polysporin, ect.) to the area unless you are allergic to these medications. Avoid sun exposure. Allow healing naturally, without irritation. Do not try to remove any scabbing.

Email us at [Josanne@spainthecity570.com](mailto:Josanne@spainthecity570.com) or  
Call (972) 998-6484 if you have any questions or concerns



**PLEASE COMPLETE THE FOLLOWING IF HAVING LASER TREATMENTS**

Which of the following best describes your skin type after 1 hour of unprotected sun exposure? (please circle one skin type #)

- I Always burns, never tans
- II Always burns, sometimes tans
- III Sometimes burns, always tans
- IV Rarely burns, always tans
- V Brown, moderately pigmented skin
- VI Black skin

Do you have a history of erythema (Abigne) which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irradiation? \_\_\_\_\_

Have you ever used Accutane, when? \_\_\_\_\_

What topical medications or creams are you currently using? Retin-A, Renova, Rentinol? (others please list) \_\_\_\_\_

Have you used any of the following hair removal methods in the past 6 weeks? \_\_\_ shaving \_\_\_ waxing \_\_\_ electrolysis \_\_\_ tweezing \_\_\_ threading \_\_\_ plucking \_\_\_ depilatories

Have you had any recent tanning or tanning products that changed the color of your skin? \_\_\_\_\_

Do you form thick or raised scars from cuts, surgeries or burns? \_\_\_\_\_

Check any of the following medications you have taken in the last 6 months (as they may increase hair growth or may be contraindications for laser treatments): \_\_\_ birth control pills \_\_\_ androgens (Rogaine) \_\_\_ Penicillin \_\_\_ cyclosporins \_\_\_ Minoxidil \_\_\_ steroids \_\_\_ Haldol \_\_\_ Phenytoin \_\_\_ thyroid medications \_\_\_ St John's Wort \_\_\_ Accutane \_\_\_ Tetracycline

**SIGNATURE**

\_\_\_\_\_  
\_\_\_\_\_

***I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, doctor or nurse of my current medical or health conditions and to update this history as a current medical history is essential for the caregiver to execute appropriate treatment procedures.***

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***I have (circle one) reviewed the medical history or reviewed the medical history and conferred with the patient. I believe there are no contraindications to the planned aesthetic procedure.***

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# SPA IN THE CITY

## Notice of Privacy Practices

Effective Date: August 1, 2011

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY.**

Protecting your privacy and maintaining the security of your protected health information is one of the most important responsibilities of this office.

If you have any questions about this notice, please contact our **Privacy Officer**.

### **Our Obligations**

We are required by law to:

- Maintain the privacy of protected health information, hereinafter designated "PHI".
- Give you this notice of our legal duties and privacy practices regarding your PHI.
- Follow the terms of our notice that is currently in effect.

### **How We May Use and Disclose Health Information**

Except for the following, we will use and disclose health information only with your written permission:

- Treatment – We may use and disclose PHI for your treatment and to provide you with treatment-related services. For example, we may disclose PHI to doctors, nurses, technicians, pharmacists, including personnel outside our office who are involved in your care and need to provide you with care.
- Payment - We may use and disclose PHI so that we or others may bill and receive payment from you, from an insurance company, or a third party for the treatment and services you received.
- Operations – We may use and disclose PHI for operational purposes. These uses and disclosures are necessary to make sure that all of our clients receive quality care, and to operate and manage our office. For example, your PHI may be shared with quality improvement personnel to evaluate the performance of our staff.
- Appointment Reminders - We may use and disclose PHI to contact you and remind you of your appointment with us.
- Individuals Involved in Your Care or Payment for Your Care - We may use and disclose PHI with a person involved in your care such as your family or a close friend.
- Research - We may use your PHI for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI has approved the research.

### **Special Situations**

- As Required by Law - We may disclose PHI when required to do so by international, federal, state, or local law.
- To Avert a Serious Threat to Health or Safety - We may disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

**SPA IN THE CITY**  
**Notice of Privacy Practices**  
**Effective 8/1/2011**

- Business Associates - We may disclose PHI to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of your PHI and are not allowed to disclose any information other than as specified in our contract.
- Lawsuits and Disputes – We may disclose PHI in response to a court order or subpoena only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- Law Enforcement - We may release PHI if requested by law enforcement official if the information is in response to a court order, subpoena, warrant, or summons.

### **Your Rights**

You have the following rights regarding your protected health information (“PHI”):

- Right to Inspect and Copy – your medical and billing records. You must make this request in writing.
- Right to Amend – you may ask to amend the information when the information is in our office.
- Right to Accounting of Disclosures – you have the right to request a list of certain disclosures we made of your PHI other than for treatment, payment, operations, or disclosures with your written authorization. You must make this request in writing.
- Right to Request Restrictions – you have the right to request a restriction or limitation on the PHI we disclose for purposes of treatment, payment, operations, or to someone involved in your care or the payment of your care, like a family member or friend. For example, you may request that we not share information about a particular treatment with your spouse. This request must be made in writing. We are not required to agree to your request.
- Right to Request Confidential Communications - you have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only by mail or at work. Your request must be in writing and must specify how or where you wish to be contacted. We will accommodate reasonable requests.
- Right to a Paper Copy of This Notice - You may ask us to provide you with a copy of this notice at any time.

### **Changes to This Notice**

We reserve the right to change this notice and make the new notice apply to PHI we already have as well as any information we receive in the future. This notice will contain the effective date on the top of the first page.

### **Complaints**

If you believe your privacy rights have been violated, you may file a complaint with our Privacy Officer or with the Department of Health and Human Services, 200 Independence Ave., SW, Washington, DC 20201. A complaint must be filed within 180 days of when the complainant knew or should have known that the act or omission complained of occurred. Filing a complaint will not interfere with your health care at this practice.



**SPA IN THE CITY, LLC**

7777 Forest Lane, Bldg D, Suite 570  
Dallas, TX 75230

**Request for Limitations and Restrictions of  
Protected Health Information “PHI”**

Note: We are not required to agree to your request. Please see our notice of privacy practices for more information regarding such requests.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_  
\_\_\_\_\_

Type of PHI to be restricted or limited: (please check all that apply)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Home Phone       | <input type="checkbox"/> Home Address          | <input type="checkbox"/> Occupation     |
| <input type="checkbox"/> Name of Employer | <input type="checkbox"/> Visit notes           | <input type="checkbox"/> Cell Phone     |
| <input type="checkbox"/> Patient History  | <input type="checkbox"/> Office Address        | <input type="checkbox"/> Office phone # |
| <input type="checkbox"/> Spouse’s name    | <input type="checkbox"/> Spouse’s office phone | <input type="checkbox"/> Email Address  |
| <input type="checkbox"/> Other: _____     |  |   |

Please explain your restrictions – be specific.  
How would you like use and/or disclosure of your PHI restricted? \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient Date

Original – file in patient chart



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Dallas, TX 75230  
(972) 998-6484

**Receipt of Notice of Privacy Practices  
Written Acknowledgement Form**

**Specifically for SPA IN THE CITY Clients**

I, \_\_\_\_\_, have received a copy

of the privacy practices of SPA IN THE CITY.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date