|  |  |
| --- | --- |
| Date |  |
| Full Name |  |
| Address |  |
| Email |  |
| Date Of Birth |  |
| Mobile Number |  |
| Emergency contact | Name Contact No. |
| How did you hear about us? |  |

**LASER CONSULTATION FORM**

**Medical Information**

|  |
| --- |
| Do you have any medical conditions that we should be made aware of before carrying out any treatments? Yes, please specify |
|  |
| Do you have any skin sensitivities or allergies? Yes, please specify |
|  |
| Do you consider your skin to be tanned currently? If yes, how long ago were you exposed to sunshine or a tanning bed?  |
|  |
| Have you taken blood thinning tablets in the last 3 months?  |
|  |

**Terms and Conditions**

The information I have given is correct to the best of my knowledge and I have not withheld any medical state or condition. I will inform the laser operator before treatment if there has been any change.

I understand that the results from this treatment vary considerably, and a small percentage of people will not respond satisfactory to treatment.

I understand that I must avoid sun exposure on the treated area for the duration of the treatment (and up to 1 month afterwards) or use a high sun protection factor to avoid sun damage. I understand that tanned skin cannot be treated.

I understand that there may be short term side effects such a reddening, bruising, swelling, mild burning or blistering, hypo – pigmentation (lightening of the skin), hyper – pigmentation (darkening of the skin), as well as the side effects such as scarring and permanent discolouration.

I understand that I must wear protective eye googles to prevent damage from the light.

I agree to follow the post treatment recommendations advised by operator/company above in order to ensure the best possible results. For Light/ Laser Treatments, I understand that excessive heat should be avoided for 48 hours and that exposure to the sun, including sun beds, must be avoided for 30 days before treatment and 30 days after treatment. A sun block of SPF 30+ must be used on the exposed skin areas, otherwise it might be possible that blotchy skin pigmentation, hyper- or hypopigmentation might occur.

I agree to co-operate with the recommendations of the company or the personnel while I am under their care, realising that any lack of co-operation could result in less than optimum results.

I agree to inform the above operator/company immediately if any adverse effects occur.

I agree to photographic documentation of the treated area prior to treatment.

I am aware that CCTV is in operation and is strictly for the security and safety of both the patient and employees working for “Essex Tattoo Removal ltd”. All GDPR guidelines are followed and “Essex Tattoo Removal ltd” is registered with the ICO.

I certify that I have read the entire informed consent and I agree to all its provisions. I certify that I have had the opportunity to ask questions and these questions have been answered to my satisfaction. I fully understand the treatment conditions and procedure.

I agree to pay for the above mentioned services and understand that there will be no refunds for any performed services. This consent form and cost covers above selected treatments only. Additional treatments can be added to this consent form and will be charged for as per clinic price list, including single shot treatments.

I have been made aware of the risks and I accept these terms and conditions as part of my treatment. We accept no liability for any of the above side effects. By accepting this, I agree to the terms and conditions and in the event of any of the above. I or any of my representative will not pursue the above person / company in any means of compensation.

I hereby authorise ***“Essex Tattoo Removal Ltd” to*** treat me.

Full Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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