DEFYNE
Med Spa & Weight Loss
Defy your age, Define your beauty

New Client Intake

TODAY'S DATE:

Welcome to Defyne Med Spa and Weight Loss. We look forward to helping you achieve your goals. The information provided by you, on this form will help determine your treatment program, so it is critical that the information you provide is accurate. Please bring this completed form with you to your first treatment.

LAST NAME	FIRST NAME	BIRTH DATE	GENDER

STREET ADDRESS	APT #	CITY	STATE	ZIP

EMAIL	CELL PHONE #	HOME PHONE #
	( )	( )

HOW DID YOU HEAR ABOUT DEFYNE?

☐ Billboard ☐ Flyer/Coupon ☐ Event ☐ Employee Referral
☐ Friend Referral Name: ☐ Online Search ☐ Flyer/Coupon ☐ Other

PLEASE HELP US ASSESS YOUR SKIN TYPE (Check all that apply)

Ethnicity: ☐ Caucasian ☐ African-American ☐ Hispanic/Latin ☐ Asian ☐ Polynesian ☐ Mediteranian

Skin Type	Skin Color	Reaction to Sun w/i 45 minutes
☐ Type 1 - 2	Caucasion/White/Pale	Almost always burns without sunscreen, fades to tan
☐ Type 3	Light Brown/Asian/Hispanic/Medit.	Burns moderately, tans easily
☐ Type 4	Med. Brown/Hispanic/Polynesian/Asian	Does not burn, tans well, heavily pigmented skin
☐ Type 5-6	Dark Brown/African-American/African	Does not burn, tans well, heavily pigmented skin

Describe your skin: ☐ Dry ☐ Oily ☐ Normal ☐ Sensitive ☐ Acne Prone

PATIENT MEDICAL HISTORY

The information provided in this section will determine your treatment schedule and laser settings. Providing accurate information will ensure that we provide you the safest and most effective treatment possible. If you have any questions, please speak with your Laser Technician prior to receiving any treatments.

Allergy	Reaction	Medication	Purpose

Do you have any tattoos or permanent cosmetics? NO ☐ YES ☐ If yes, where_____
Have you ever taken Accutane? NO ☐ YES ☐ If yes, when_____
Do you have Herpes or have you ever had a "cold sore"? NO ☐ YES ☐
Have you been diagnosed with Polycystic Ovarian Syndrome (PCOS): NO ☐ YES ☐
Are you taking any photo-sensitizing medications? NO ☐ YES ☐ If yes, please list above
Are you currently using self-tanning products? NO ☐ YES ☐
For women, are you currently pregnant or nursing? NO ☐ YES ☐
Do you have any present illnesses? NO ☐ YES ☐ If yes, what _____
Do you have a family history of cancer? NO ☐ YES ☐ If yes, type_____
Do you have any thyroid abnormalities? NO ☐ YES ☐
Do you have problems healing from a cut or burn? NO ☐ YES ☐
Have you been treated with BOTOX or other injectables? NO ☐ YES ☐ If yes, when_____
Have you ever had a histamine (allergy) reaction to the sun? NO ☐ YES ☐
Are you currently using any BHA/AHA (Glycolic or Salycilic) products? NO ☐ YES ☐ If yes, what_____
Are you allergic to Lidocaine or any other anesthesia? NO ☐ YES ☐
Are you allergic to Latex? NO ☐ YES ☐
Are you allergic to Aspirin? NO ☐ YES ☐
Are you taking regular doses of Aspirin or blood thinners? NO ☐ YES ☐

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS OR ARE YOU USING THE FOLLOWING PRODUCTS? :

- ☐ Active Herpes/Cold Sores
- ☐ Hirsutism
- ☐ PCOS
- ☐ Photosensitivity
- ☐ Hairy Moles
- ☐ Skin Cancer
- ☐ Thyroid Conditions
- ☐ Seizures
- ☐ Smoking
- ☐ Active Viral Infection
- ☐ Active Bacterial Infection
- ☐ HIV/AIDS
- ☐ Warts/HPV
- ☐ Psoriasis
- ☐ Keloid Scarring
- ☐ Bleeding Issues
- ☐ Cancer Treatments
- ☐ Iron Supplements
- ☐ Hormone Therapy
- ☐ Accutane
- ☐ Antibiotics
- ☐ Medical Implants/Devices
- ☐ None of the Above

REFUND POLICY

- Pre-paid services/packages may be returned within 2 weeks of purchase, for 75% of the original purchase price.
- Initiated or completed services/packages will not be refunded regardless of treatment results. •
- Any unused portion of a service/package may be applied to any other package or spa service. Completed treatments will be deducted at the full single visit price, when determining the remaining credit available.
- Allow 2 weeks for all refunds. Allow 45 days for all refunds over $1000.
- All make-up and skin care products may be returned within 30 days for a full refund.
- No refunds will be given after 30 days.

DISCOUNT POLICY

- Coupons and monthly specials will not be honored past expirations dates.
- Free Gift Certificates (received as a gift or through marketing, trade show, or radio promotions) may not be redeemed for injections or weight loss services or products, unless indicated on the gift card.

TREATMENT DISCLOSURES - READ PRIOR TO SIGNING THIS FORM

- I am not using any photosensitizing drugs or products, or have had the risks explained to me and given my consent to continue treatment.
- I understand that UV exposure 2 weeks pre or post treatment greatly increases my risks of experiencing side effects from laser and esthetics services.
- I have been informed that my treatment results may vary if I am pregnant. I have disclosed my pregnancy status to Defyne Med Spa & Weight Loss and agree that if my status changes, I will inform Defyne prior to treatment.
- I understand that I cannot have any laser or esthetics services if I have used Isotretinoin (Accutane®, Amnesteem®, Claravis®, Sotret®) within the last 6 months. I have not used Isotretinoin within the last six months and I will inform Defyne if this status changes.
- I have reviewed and understand what to expect from my treatment and the potential side effects I may experience due to this treatment.
- I have reviewed and understand the pre & post care instructions for the treatments I will be receiving.
- I understand that Defyne does not guarantee any specific results from any treatment.I have reviewed and understand the limitations of the treatments I will be receiving. I am aware that laser hair removal treatments are not effective on RED, BLONDE OR GREY hair. On average, hair removal clients can expect 70-90% reduction after 8-12 treatments.
- I agree that if I experience any side effects from my treatments that I will contact Defyne and allow them to review and treat my condition prior to my visiting another health care provider. If I choose to visit another provider without first reviewing my condition with Defyne, I understand that Defyne may not provide reimbursement for new charges, fees, and/or treatments.
- I consent to being treated with the products determined necessary by Defyne. I have informed Defyne of any known product allergies that I may have.
- I have discussed my desired treatment and have been informed of the estimated cost.
- I understand that Defyne uses FDA approved products and equipment for off-label uses.

SIDE EFFECTS DISCLOSURES - READ PRIOR TO SIGNING THIS FORM

I understand that I will receive pre and post treatment care information for each Defyne service. Prior to my treatment I will receive a consultation in which side effects, and the care for such side effects, will be explained to me. I understand that for most cosmetic procedures, a series of treatments is recomended for optimal results. I understand that Defyne cannot predict or guarantee any results. I agree that if I experience any side effects from my treatments that I will contact Defyne and allow them to review and treat my condition prior to my visiting a health care provider. If I choose to visit another provider without first reviewing my condition with Defyne, I understand that Defyne will not provide reimbursement for new charges, fees, or treatments. Below are the most common side-effects of each treatment:

Laser Hair Removal: Hyperpigmentation (darkening of skin), hypopigmentation (loss of skin pigmentation), mild to moderate burns (2nd degree), blisters, temporary redness, follicular edema (little pink/red "puffiness" and small bumps like "goose bumps") swelling and itching in treated area, hives, skin rash, bruising, scarring and a lack of desired results.

BOTOX, Dysport & Fillers: Headaches, respiratory infection, flu symptoms, redness at injection site, temporary eyelid ptosis (drooping), bruising, pin point bleeding, vascular occlusion, skin rash, infection, itching, product nodules at injection site, numbness, asymmetry, tenderness at injections site, infection, and lack of desired results.

Laser Skin Rejuvenation: Transient erythema (redness), edema (swelling), burning sensation, and pruritus (itching), milia, acne exacerbation, contact dermatitis, or perioral dermatitis. Moderate complications include localized viral, bacterial and candidal infection, prolonged erythema, transient post treatment hyperpigmentation, and delayed hypopigmentation. Severe but rare complications include fibrosis, hypertrophic scarring, disseminated infection, scarring and the development of ectropion.

Laser Skin Lightening/TighteningVeins: Hyperpigmentation (darkening of skin), hypopigmentation (loss of skin pigmentation), mild to moderate burns (2nd degree), blisters, temporary redness, follicular edema (little pink/red "puffiness" and small bumps like "goose bumps") swelling and itching in treated area, hives, skin rash, bruising, scarring and a lack of desired results.

Chemical Peels, Dermapen, Facials, and Microdermabrasion: Minor burns, hypopigmentation, hyperpigmentation, streaking, allergic reaction, bruising, scarring and lack of desired results.

Product Applications: Minor burns, allergic reaction, and lack of desired results.

Latisse: Discoloration around the eye rims, discoloration of iris, dry eyes, itching.

INFORMED CONSENT TO TREAT - PLEASE READ AND SIGN

CONSENT TO TREAT: I voluntarily consent to receive treatment ("Services") at Defyne and to the use of all products ("Products") related to the Services provided by Defyne.

PRODUCT CONSENT: I understand that it is my responsibility to review product ingredients and make Defyne aware of any possible allergies prior to having products applied. I understand that Defyne is not responsible for any reactions to products purchased at Defyne and applied outside of the facility. I have provided Defyne with an accurate medical history.

SIDE EFFECTS & RISKS: I have thoroughly reviewed the Side Effects Disclosure and I understand the risks associated with the Services and Products. I agree that if I experience any side effects from my treatments that I will allow Defyne to review and treat my condition prior to my visiting another health care provider.

ACKNOWLEDGEMENT OF RECEIPT OF TREATMENT INFORMATION: I have received documentation on my procedure including possible side effects, pre/post care instructions, and what to expect before and after treatment I agree to request such information if not provided to me for all new services provided to me at Defyne.

STATEMENTS OF FINANCIAL RESPONSIBILITY, PAYMENT & NO SHOW: I understand that Defyne requires 24 business hours notice for cancellations or rescheduling. I understand that I will incur a $20.00 cancellation charge if I fail to keep my appointment and I fail to give the proper cancellation notice. I understand that I will be responsible for paying all costs and expenses associated with my failure to pay any amounts owed to Defyne, including, all returned check fees, reasonable attorney fees, court costs, and any other related collection costs and expenses. I understand that if I enter into a payment program with Defyne (or any third-party operating on my behalf or on behalf of Defyne) I am responsible for all agreed upon payments regardless of treatment results or any change in personal circumstances.

GUARANTEE & REFUNDS: I understand that Defyne does not guarantee results or make any promises as to the effectiveness of my treatment. I understand that the required number of treatments varies for each client and for each treatment. I understand Defyne will make its best effort to provide an estimate of cost and treatment needs, but cannot guarantee any individual results. I understand that Sublime will not refund my purchase due to less than average results or because I experience side effects from treatments.

PHOTOGRAPHY & MEDICAL IMAGING: I understand that before and after photograph may be taken for documentation. I hereby give consent to Defyne to take photographs of me as needed during my treatments. I ____ authorize/ ____do not authorize Defyne to use such photographs for purposes of training, professional publication, education or marketing.

I REPRESENT THAT I WAS ABLE TO RAISE ANY CONCERNS WITH DEFYNE ABOUT MY TREATMENT INCLUDING ALL RISKS AND TREATMENT OPTIONS. MY QUESTIONS AND CONCERNS HAVE BEEN DISCUSSED AND ANSWERED TO MY SATISFACTION. I HAVE HAD THE OPPORTUNITY TO READ AND I FULLY UNDERSTAND THIS "CONSENT TO TREAT" AND I AGREE TO ITS CONTENTS. I WILLINGLY ASSUME THE RISKS ASSOCIATED WITH MY TREATMENT. BY SIGNING THIS FORM I UNDERSTAND THAT ALL AGREEMENTS MADE BY ME IN THIS DOCUMENT ARE APPLICABLE TO ALL FUTURE SERVICES RECEIVED BY ME AT DEFYNE MED SPA AND WEIGHT LOSS.

CONSULTATION DATE: _____ STAFF SIGNATURE: _____

TO BE COMPLETED BY MEDICAL SUPERVISOR

Pre-evaluation Checklist

I certify that I have conducted an in-person evaluation with this patient. I have reviewed this patients medical history and have cleared him/her for the requested treatments and products.

I have provided the patient with opportunity to review pre & post care instructions, understand potential side effects and risks and to ask additional questions.

I have delegated the performance of the requested treatments to a qualified technician and have instructed them to peform such treatments according to:

☐ Standard Defyne treatment protocols

☐ Modified Defyne treatment protocols as outlined below:

_____

_____

MEDICAL SUPERVISOR SIGNATURE DATE

CLIENT SIGNATURE **DATE**