Raymond Wayne Whitted MD, MPH, L L C
Patient Information

Patient Name:_____ Home Phone:_____
Nombre del Paciente *Telefóno del Hogar*
Home Address:_____ Work Phone:_____
Direccion del Hogar *Telefóno del Trabajo*
City:_____ State:_____ Zip Code:_____ Date of Birth_____
Ciudad *Estado* *Codigo Postal* *Fecha de Nacimento*
Occupation:_____ Social Security:_____
Ocupacion *Numero de Seguro Social*
Employer:_____ Marital Status:_____
Empleo *Estado Civil*
Emergency Contact:_____ Phone Number:_____
Contacto de Emergencia *Telefóno*
Referred By:_____ Driver's License #:_____
Referido Por *Numero de Licencia de conducir*
Allergies/Alergias:_____ E-mail address:_____
** IF YOUR VISIT IS FOR A WELL WOMAN EXAM, CHECK HERE:____ Si su visita es para un examen annual, marque aqui:____

INSURANCE INFORMATION

Name of Primary Insurance: _____
Nombre del Seguro
Address:_____ Phone Number:_____
Direccion *Telefóno*
Group Number:_____ Policy or I.D. Number:_____
Numero de Grupo *Numero de Poliza*
Name of Subscriber:_____ Date of Birth:_____ Relation to Patient: _____
Nombre del Asegurado *Fecha de Nacimeinto* *Relacion al Paciente*
Subscriber's Employer: _____
Empleo del Asegurado
Name of Secondary Insurance: _____
Nombre del Seguro Secundario
Address:_____ Phone Number:_____
Direccion *Telefóno*
Group Number:_____ Policy or I.D. Number:_____
Numero de Grupo *Numero de Poliza*
Name of Subscriber:_____ Date of Birth:_____ Relation to Patient: _____
Nombre del Asegurado *Fecha de Nacimeinto* *Relacion al Paciente*
Subscriber's Employer: _____
Empleo del Asegurado

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept Visa, Master Card. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of your policy. Final payment for all charges is the patient's responsibility and should ib be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees and court costs.

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos Visa, Master Card. Su seguro medico es un contrato entre usted y compania de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esda deuda, usted es responsable de los gastos legales.

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgments up to the minimum amounts pursuant to S.458.320 (5)(g). Florida Law imposed penalties against non-insured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is pursuant to Florida Law.

PHYSICIAN'S RELEASE AND ASSIGNMENT

Thereby authorize payment directly to Raymond Wayne Whitted MD, MPH, LLC. of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by Raymond Wayne Whitted, LLC. I understand that I am financially responsible to Raymond Wayne Whitted MD, MPH, LLC for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente a Raymond Wayne Whitted MD, MPH, LLC, todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compania de seguro para processar mi reclamacion. Yo entiendo que soy responsable por todos los cargos no cubiertos bajo mi seguro medico.

1. I, the undersigned patient or _____ (name of authorized representative acting on behalf of patient) consent to undergo all necessary tests, medication, treatments, and other procedures in the course of the study, diagnosis, and treatment of my illness (es) by the medical staff and other agents and /or employees of Raymond Wayne Whitted MD, MPH, LLC. The identity of the physician who currently has primary responsibility for my care has been provided to me.
2. I understand that, absent emergency or extraordinary circumstances, non-routine and major medical procedures will not be performed upon me until I have had an opportunity to discuss and agree to them with a physician.
3. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of diagnosis, examinations or treatments in the hospitals or offices.
4. I hereby authorize the staff of Raymond Wayne Whitted MD, MPH, LLC to take such still photographs, motion pictures, television transmissions, and/or videotaped recording for educational and evidentiary purposes as they may wish.
5. I hereby grant access to medical records for bona fide research to members of the medical staff and other medical researchers and authorize my medical records and results to be used for research. I realize that my records will not be identified as pertaining to me specifically without my expressed permission.
6. I consent to the release of medical information to other institutions, agencies, health care organizations, or health care providers accepting the patient for medical or institutional care, and consent to the release of medical information to the patient's insurer and/or managed care organization and their agents for purposes including but not limited to Utilization Review and Quality Assurance Review.
7. I hereby authorize payment directly to Raymond Wayne Whitted MD, MPH, LLC of benefits due to me in my pending claim and/or MAJOR MEDICAL BENEFITS otherwise payable to me, but not to exceed the Hospital and/or Physician's regular charges for this period of treatment. I agree that a photostatic copy of this authorization is as valid as the original.

I have read and clearly understand the above.

_____ Date:_____ Time:_____ AM/PM
Signature of patient or patient's authorized representative

_____
Witness' Signature

MINOR'S CONSENT: Un-emancipated patients (minors under 18 years of age) must have parents or guardians signature, except for emergency medical care, diagnosis or treatment of a sexually transmitted disease, or treatment of pregnancy.

_____
Parent or Guardian's Signature

EMERGENCY CONSENT: Patient is unattended by legal guardian, health care surrogate, or relative and/or unable to sign consent for treatment necessary to correct or stabilize a serious medical condition (s) demanding immediate medical attention. I certify that this condition will endanger the life, limb or health of the patient and authorize emergency procedures

_____ Date: _____ Time: _____ AM/PM
Physician's Signature

Raymond Wayne Whitted MD, MPH

...dedicated to healthy lifestyles and safe, state-of-the-art, innovative surgery for women of all ages
...because quality is an experience!

www.drwhitted.net

R. Wayne Whitted MD, MPH
Diplomate, ABOG
Certified in Advanced Laparoscopy
Certified in Advanced Hysteroscopy
Certified Menopause Clinician
Certified Bone Densitometrist
Certified Researcher
Certified Wartime Surgery

COMPREHENSIVE GYNECOLOGY & MINIMALLY INVASIVE SURGERY
Abnormal Pap Smears
Advanced Colposcopy
Abnormal Periods
Bladder Prolapse
Chronic Pelvic Pain
Endometriosis
Ectopic Pregnancy
Family Planning
Fibroids
Genital Warts
Immunizations
Loss Of Urine
Menopause
- Risk Assessment
- Support Series

Ovarian Cysts
Rectocele
Surgical Gynecology
- Hysteroscopy
- Laparoscopy
- Vaginal Surgery
- Surgical Support Series

Uterine Prolapse
Vaginal Prolapse
Vaginal Infections
Vulvodynia/Vestibulitis
Well-Woman

AESTHETIC GYNECOLOGY
Botox
Vaginal Rejuvenation
Permanent Hair Removal

OFFICE PROCEDURES
Hysteroscopy
LEEP cone biopsy
Cryosurgery
Dilation and Curettage
Ultrasound
Urodynamics/Bladder Studies
Heel Density Scan

COMPREHENSIVE RESEARCH
Laparoscopy
Hysteroscopy
Menopause
Women's Health

EDUCATORS
Community Programs
CME Programs
Surgical Preceptor

MEMBERSHIPS
Obstetrics and Gynecology
Gynecologic Laparoscopy
Bone Densitometry
Colposcopy and abnormal paps
Physician Executives
Honor Medical Society
Best Doctors

Notice of Privacy Acknowledgement

Notificacion De Privacidad En Las Practicas Medicas

I have read and understood the Notice of Privacy Practices.

(Yo he leido y comprendo la Notificacion de Privacidad en las Practicas Medicas)

Date (Fecha)_____

Patient's Name Printed (Nombre de Patiente) _____

Patient's Signature (Firma de Patiente)_____

Witness _____

8740 N. Kendall Drive, Suite 101, Miami, Florida 33176
Phone 305 596 3744 ● fax 305 596 3676● www.drwhitted.net

Raymond Wayne Whitted MD, MPH, FACOG

…dedicated to safe, state-of-the-art surgery and health life-styles for women of all ages
…because you deserve the best!

www.drwhitted.net

R. Wayne Whitted MD, MPH
8740 N Kendall Dr. Suite 101
Miami, Florida 33176
Phone: 305-596-3744

As part of our commitment to women's healthcare we now offer a variety of Aesthetic/Cosmetic enhancement procedures using the McCue Energist Ultra Variable Pulsed Light system (VPL). The VPL is one of the most recent advancements for virtually PAINLESS permanent hair removal. In addition, with this we can treat a variety of other skin abnormalities: SUN-DAMAGED SKIN, THREAD VEINS, STRETCH MARKS, ANGIOMAS AND MORE.

HAIR REMOVAL

Goal - Destroy the hair follicle and achieve 'hair free'. Laser and Pulsed Light are both Light based ways to do hair reduction. These Light based treatments only work on hair that is in the active growing, or Anagen, phase. At any given time, only about 25% of the hair on our body is in the appropriate stage (phase) for treatment. The other 75% cannot be affected by light treatments. That is why it is necessary to perform multiple treatments with Laser and with Pulsed Light.

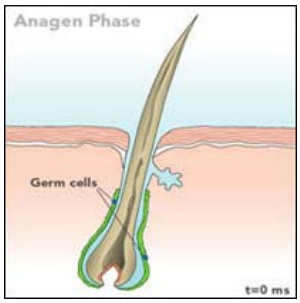
How - Traditional Laser and Intense Pulsed Light systems convert light energy into heat. The Melanin in hair absorbs more of the heat than the surrounding skin tissue. The heat transfers down the hair shaft, and if the temperature at the base of the hair shaft reaches 70° C, the follicle will be destroyed - no more hair!

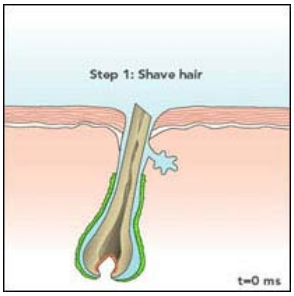
VPL™ takes this process a step further. By changing the number of pulses in each 'shot', the length of the individual pulses, and most importantly the space, or Delay, between each pulse, the ULTRA can more specifically target different color hairs on different skin types.

The **ULTRA VPL**™ is the most versatile (and effective) hair removal system that you can buy!

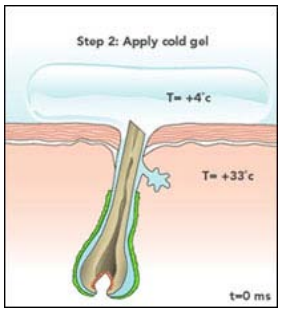
Treatments

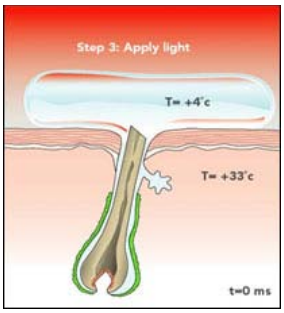
- Active growth stage.
- Shave the area to be treated.

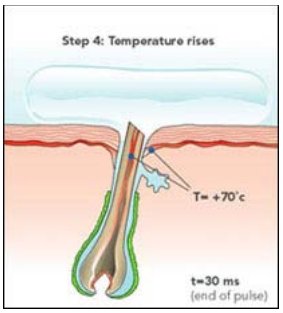


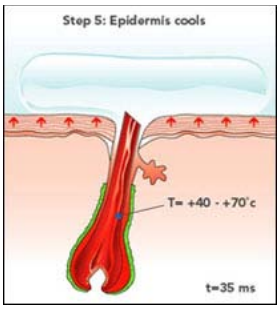


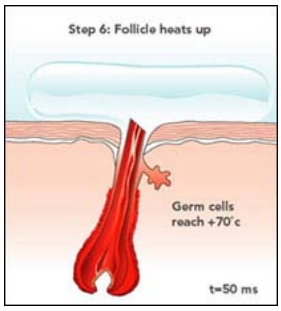
- Apply a thin layer of gel to the area. This gel acts as a 'coupler' which intensifies the light, and makes a great guide for the area to be treated.

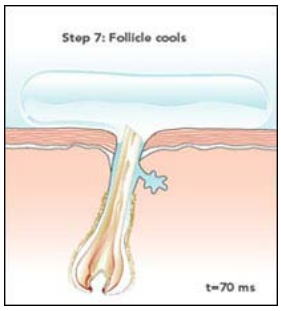


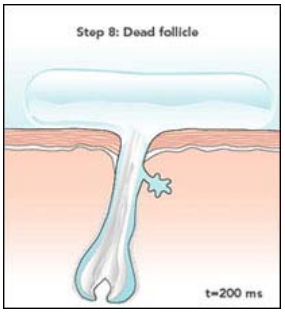












SKIN TREATMENTS USING VPL SYSTEMS

The concept of using Intense Pulse Light sources for the treatment of many skin conditions associated with the aging process is currently receiving considerable interest within the professional beauty industry and the general public. There exists today a rapidly growing demand for addressing the signs of aging with safe simple techniques. Until the recent introduction of Intense Pulsed Light (IPLT) and more recently Variable Pulsed Light (VPL™) treatment (initially, successfully developed for hair depilation), the only available treatments included surgery, chemical peeling, ablative and non-ablative resurfacing, microdermabrasion and various visible light and near IR laser treatments.

VPL skin treatment is a process that has many advantages over other treatment modalities as it effectively treats a combination of changes in the skin, from the signs of ageing, over exposure to the sun, broken facial capillaries, pigmentary abnormalities and cosmetic imperfections.

Sun Damaged Skin

Sun damaged skin occurs as the result of excessive exposure to ultraviolet (UV) light, which induces epidermal and dermal changes. Skin affected in this way is characterised by thinning of the epidermis and dermis, coarse skin texture, wrinkling, Telangiectasias and changes in pigmentation.

The overall appearance of sun-damaged skin relates to the resultant UV damage of structural components such as collagen and elastin fibres. Appearance is also affected by genetic factors, intrinsic factors, disease process such as Rosacea, and the overall loss of

cutaneous elasticity associated with age. More people now have extended periods of sun exposure and, coupled with the thinning of the ozone layer and other factors, this has resulted in visible signs of ageing, damage and disease evident in ever-younger people. People in their twenties and thirties are now witnessing solar elastosis, Telangiectasia, solar lentigines and rhytide formation.

Treatment Process

The McCue **ULTRA VPL™** System is suitable for full face, neck, chest and hands treatment to improve the visible signs of sun damage and ageing.

The treatment of sun-damaged skin includes treating both benign pigmented and vascular lesions. Exposure to UV light destroys skin cells thereby slowing down the growth of new skin and the production of collagen. The increase in blood flow as a result of the treatment to the region will also bring fresh supplies of oxygen and nutrients to the cells, which will assist in the removal of waste. By traumatizing the epidermis and dermis the skin will also be encouraged to go into 'repair mode' increasing cell turnover

***Other treatments using the McCue ULTRA VPL™ include the following:

- The treatment of benign pigmented epidermal and cutaneous lesions including **warts, scars, chloasma, and striae.**
- The treatment of benign cutaneous vascular lesions including **port wine stains, Hemangiomas, facial, truncal and leg telangiectasias, Rosacea, melasma, angiomas and spider angiomas, poikiloderma of Civatte, leg veins, facial veins and venous malformations**

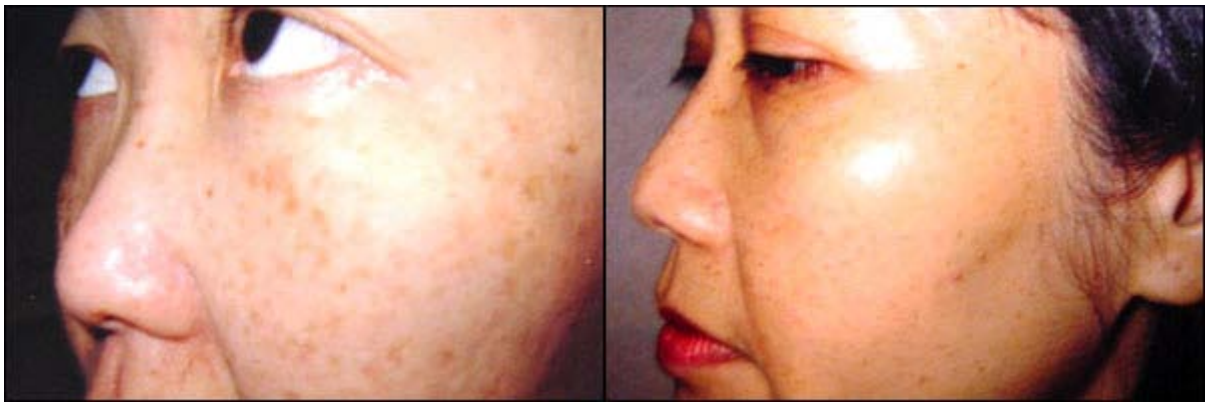
Benign Pigmentation Treatment

Benign pigmented conditions are caused by the melanocytes having an irregular production of melanin. The treatment involves the 'disabling' of rogue melanocytes by directing energy of the correct fluency and wavelength to these over-producing melanocytes, which automatically absorb more energy than normal melanocytes because of their darker color. Following treatment the production of melanin will become normal and the skin will return to its ambient color. Energy fluency settings sufficient to cause erythema in the ambient skin areas are usually sufficient to disable those melanocytes in the darker skin pigmentation.

Number of treatment sessions required

Generally, between four to six treatment sessions are required, although it depends upon the treatment type and the area being treated. A good 'rule-of-thumb' is to assume one treatment for each decade of a person's life. The number of treatment sessions may increase when treating darker skin types. Normally, these treatment sessions are carried out at three week intervals.

3 Treatments at 3 week intervals



Areas to be Treated

Abdomen	Armpits	Back	Bikini	Buttocks	Cheeks	Chest
Chin	Ears	Eyebrows	Feet	Fingers	Forearms	Full Arms
Full Legs	Hands	Lower Legs	Neck	Shoulders	Thighs	Upper Arms
Upper Lip	Other _____					

What are your realistic goals?

What concerns do you have regarding treatment?

Do you have any questions regarding the treatment procedure?

Hair Removal

Number of treatment sessions required

Generally, between **three to six treatment sessions** are required, although it depends upon the area being treated. The aim of each treatment is to reduce the hair density successively to a level that is satisfactory to the client.

The number of treatment sessions may increase when treating darker skin or lighter hairs since the percentage of hair removed during each treatment will be reduced in these instances.

Period between successive treatments

Due to the cyclical nature of hair growth, a number of treatments are required in order to ensure that treatment covers the growth stage of all follicles. **It is only during the growth stage, with the hair present, that the follicles can be successfully treated.**

It is recommended that each treatment be performed once when the next phase of hair has grown through, this time period varies depending on the area of the body and on the individual. For example, the hair on the upper lip has a growth cycle of approximately 6 weeks, whereas the growth cycle for leg hair is about 24 weeks, so it may not be necessary for a Client to return for a second treatment on their legs until about 8 weeks later. Since growth cycles can vary significantly between individuals, a good indication of the period between successive treatments can be obtained from the Clients themselves. When the Client considers that they have a full re-growth of hair then it is most probably time for the next treatment.

Note: At the start of each subsequent treatment the same safety steps that are recommended for the first treatment should be completed. To ensure that subsequent treatments produce favourable results, the Client must inform the Operator if any pigmentary changes have occurred. If so then these should be assessed individually, but generally an increase in the amount of melanin in the skin would indicate that a lower energy should be used.

What to Expect After Treatment

The immediate after effect is that the treated area should become slightly red, particularly around the hair. Typically, this redness will disappear in a matter of a few hours at most (and often in just a few minutes) with the skin then returning to its normal color. The hair will still be in place in the follicle since the treatment, unlike laser, is not a vaporizing process.

During the next ten days or so the hair will appear to continue growing, albeit more slowly than before. What actually is happening is that the hair is no longer supported by the follicle but is being pushed out by the growth of the epidermix which is still in close contact with the hair shaft. If left alone, the treated hairs will fall out naturally after a period of between one and three weeks, dependent on the depth of the hair root. The hair is acting as an effective barrier to infectioin of the inflamed follicle, and so they should not be removed prematurely.

After Care

Immediately following the treatment session, or at regular intervals in the case of treatment of large areas, soothing gel should be applied to the treated area. Recommended gels include Witch Hazel, Tea Tree or Aloe Vera. These gels have the effect of cooling the area and generally include antiseptic properties to protect the damaged follicle against opportunistic infections.

The Client should be advised to refrain from using cosmetic make-up, perfumed soaps and similar products for about 24 hours following treatment. Also, exposure to the sun should be avoided for about one month unless a high factor sun block is used as a precaution against exacerbating any pigmentary changes which may not be immediately evident.

Health History Form

Patient Number:	Address
Patient Name	
Date of birth	
Sex: ☐ Female ☐ Male	Doctor's Name:
Operator's Name:	Date:

It is not recommended that treatment be carried out on Clients suffering from the following (CONTRAINDICATIONS)

Pregnancy
Epilepsy (flashes of light may cause seizures)
History of light sensitive rashes
Recent suntan (within 1 week)
Undertaking treatment involving blood thinning medication (possible bleeding)
History of Keloids
Oral acne medication in the last six months (Accutane)
Photosensitivity in the last six months
Medication for which sunlight is contraindicated (see information on drug induced photosensitivity)
Kaposi's sarcoma
Malignant or suspicious tissues
History of poor wound healing
Tattoo over treatment area

Conditions that require a medical consultation prior to treatment:

Hairy Moles (can be precancerous)
Diabetes (issues with tissue healing)
Contraindicated Medications
Malignant or suspicious lesions (a sight of therapy)
Hemophilia
Photosensitivity

Please answer the following questions: Please circle the appropriate answer

Skin type **Oily** **Sensitive** **Dry** **Other**

Skin Color **White** **Olive** **Oriental** **Indian** **Afro-Caribbean**

Skin Conditions

Moles	**Freckles**	**Acne**	**Psoriasis**	**Eczema**
Shingles	**Herpes**	**Keloid**	**Pigmented patches**	**Vitiligo**

What other cosmetic procedures have you undertaken? Please Circle

Face Lift **Laser Resurfacing** **Hair Removal** **Botox** **Cosmeceuticals** **Chemical Peels**

Pulsed Light **Dermabrasion** **Other:** _____

How would you describe your reaction to the sun? Please Circle

Type 1 (1): Always burn, never tan

Type 2 (2): Sometimes burn, then tans

Type 3 (3): Always tan, rarely burns

Type 4 (4): Rarely burns, tans with ease

Type 5 (5): Moderately pigmented, tans profusely

Type 6 (6): Deeply pigmented, never burns

Are you taking medications that may make your skin photosensitive?

Yes **No** _____

_____

Photosensitivity

There are many forms of medication and products available that can cause the skin to become sensitive to light. These drugs can be taken by mouth or applied to the skin, therefore it is important to ascertain whether the client is currently using these products or undergoing a course of medication.
When receiving a light based treatment, a reaction can sometimes occur, with varying degrees of severity. This varies greatly from client to client and ranges from no noticeable reaction through to blisters and severe skin responses. This reaction is called “Drug-Induced Photosensitivity” and can be divided into two groups:
Photo-toxic Reactions: these are dose related and can be seen to slight degree in people who are exposed to sunlight.
Photo-allergic Reactions: these involve the immune system and may be similar to other allergic reactions such as swelling, rashes and hives.

It is due to these reactions that it is advisable to ensure test patches are performed to determine if any adverse reaction occurs.

Common Drugs that can cause photosensitive reactions:

Use of these drugs does not exclude a patient from treatment but a test patch should Be performed and patient should sign a release:

Xanax, Elavil, Benzocaine, captopril, Librium, Chloroquine, Tetraccline, Ciprofloxacin, Bactrim, Dapsone, Diltiazem, Benadryl, Penetrex, 5-FU, Glyburide, Griseofulvin, Haldol, Hydralazine, Advil (Motrin), Isoniazid, Accutane, Methotrexate, Rogaine, Naprosyn (aleve), Nifedipine, Norfloxacin, Nortriptyline, Birth Control Pills (estrogen of any kind), Floxin, terramycin, Perfenazine, Phenylbutazone, Dilantin, Feldene, Compazine,

Phenergan, Vivactil, Quinidine, Quinine, Sulfur antibiotics, Mellaril, Navane, Tolinase, Retin-A, Stellazine, Vitamin A

Initials _____

COMMON DRUGS THAT CAN CAUSE PHOTOSENSITIVE REACTIONS
*indicates high incidence of drug induced photoreactions

Antibiotics
Doxycycline, Demeclocycline, Tetracycline, Vibramycin
Declomycin
Nalidixic Acid
Fluoroquinolones
Blood Pressure & Heart Medications
Hydrochlorothiazide
Furosemide
* Amiodarone
Drugs
Phenothiazines
PABA and or PABA esters
Herbals:
St. Johns Wort
Melaton in
Kava Kava

Initials _____

Do You Have any Allergies?	**Yes**	**No**
Do You have personal history of skin cancer?	**Yes**	**No**
Do You have any medical condition or serious illness?	**Yes**	**No**

If yes, _____

Treatment Checklist (Complete before each treatment)

1. Does the patient have any of the contra-indications?	Yes	No
2. If the patient has a sun tan, was it within the last 4 weeks?	Yes	No
3. Does the patient have any skin abnormalities which may be of concern?	Yes	No
4. If the patient has received previous treatments, have they had any problems?	Yes	No

CONSENT FORM

NAME _____ DOB _____ DOS _____

PHONE _____ ADDRESS _____

I understand that the procedures is an elective cosmetic procedure and hereby acknowledge the following:

_____1. I understand that the extent of the effectiveness of the treatment using intense pulsed light varies from person to person and therefore the response to treatment can also vary.

_____2. I would like the following area of my body to be treated: _____

I understand that immediately following treatment (post) the area may appear reddened and there is a slight chance that small blisters may appear.

_____3. I understand also that following the first treatment I may not see an immediate effect and will need to have a second/third/fourth/future treatment.

_____4. I understand that, following treatment, there is a slight possibility, that depigmentations of the area being treated may occur causing the skin to appear darker. These symptoms, should they occur, are usually temporary and slight but there is no absolute guarantee that all normal pigments returns. I understand that there is a very slight risk of scarring with any skin treatment but in this case it is extremely small.

_____5. I confirm that I have provided the office/Operator with any medical details, which may be relevant to my treatment.

_____6. Photos are used to follow treatment and will be kept confidential and in your personal record.

My signature below constitutes my acknowledgement that I have read, understand and fully agree to the proposed treatment and that the process has been satisfactorily explaned to me and I have all the information which I require.

Patient Signature _____ **Date** _____

Witness _____ **Date** _____

Pre and Post Treatment Instructions

PULSED LIGHT HAIR REDUCTION

1. **The Area being treated cannot be exposed to the sun. A broad spectrum (UVA/UB) sunscreen SPF 30 or greater should be applied whenever exposed to the sun. A sunscreen is available for purchase in our office if you do not have one.**
2. **Do not tweeze, wax, or use a depilatory agent for one month prior to treatment.**
3. **The area should be shaved 24-36 hours prior to treatment. A small stubble must be visible.**
4. **Makeup, deodorant, perfumes or powder must be removed on the areas to be treated.**
5. **Your treatment cannot be performed if you have a suntan or sunburn.**
6. **Immediately following treatment, the area may show slight to moderate redness with some swelling. Blistering my occur.**
7. **During the healing phase, the area must be treated delicately. Do not rub, scratch, or pick. If a crust develops let it fall off on its own.**
8. **Apply a thin layer of post laser lotion to the treated area several times a day to keep the area moist.**
9. **Do not scrub the area. Pat the area dry. Do no shave over the area if swelling, crusting, or scabbing is present.**
10. **If swelling occurs, you may apply ice wrapped in a soft cloth. Any discomfort or stinging can be relieved with Tylenol.**
11. **If makeup is allowed, it must be applied and removed delicately. Excess rubbing can open the treated area, increasing the chance of scarring.**
12. **Avoid excess perspiration for 48-72 hours after treatment.**
13. **In case of signs of infection (pus, tenderness, fever), contact the office immediately.**
14. **The treated hairs will exfoliate or push out in approximately two weeks.**

They do not fall out immediately.

Patient Signature _____ Date _____

Witness _____ Date _____

POST-TREATMENT CARE INSTRUCTIONS

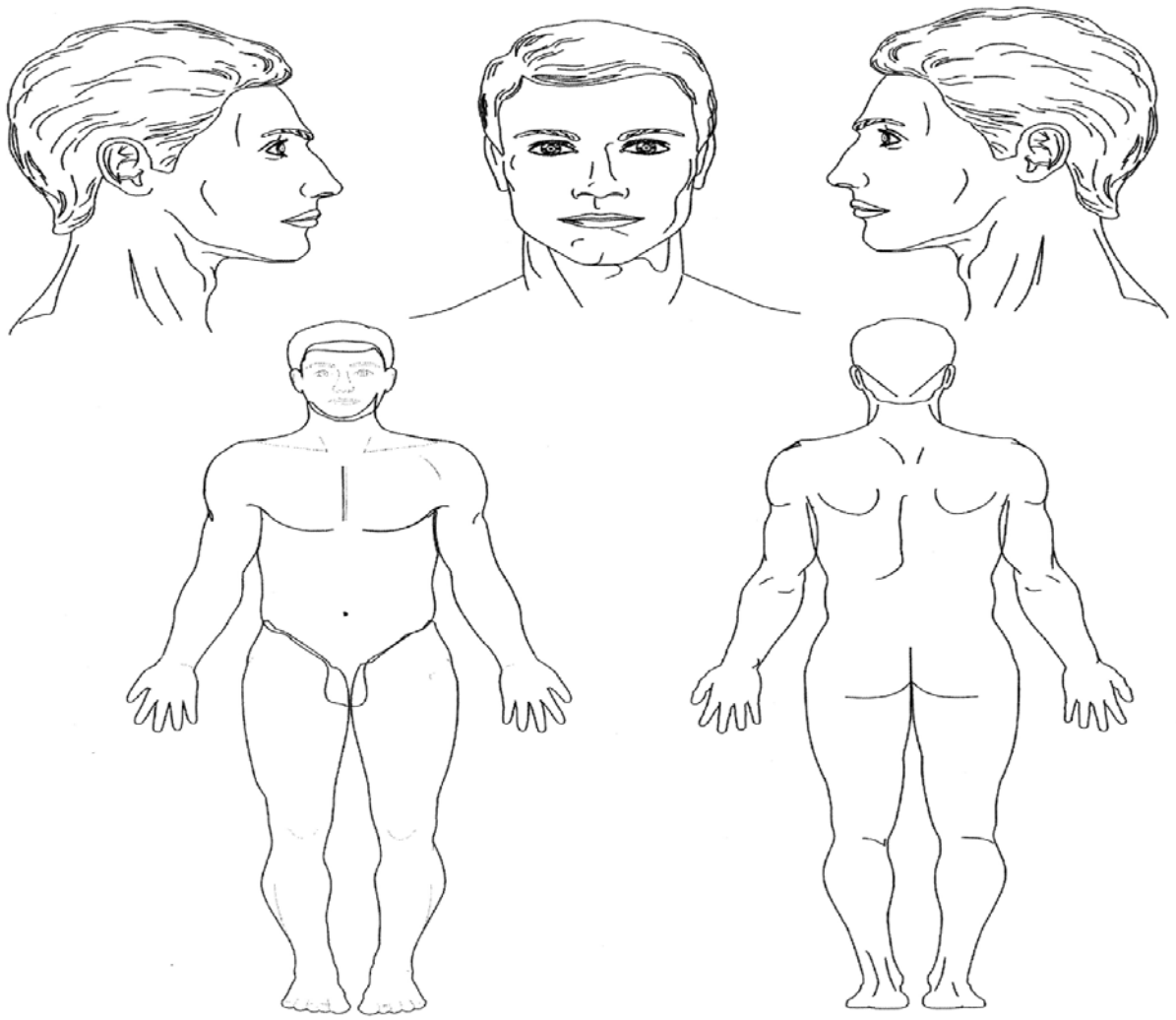
Skin Treatments

1. **The area treated may be red and warm for a few hours following treatment. If this is uncomfortable the patient should cool the area with a cold flannel/towel or some other means of cooling. Do not use an icepack as this may cause an "ice burn".**
2. **Soothing preparations may be used providing they do not contain anti-inflammatory or blood thinning properties. The patient should avoid preparations such as Aloe Vera, Tea Tree Oil, Ibuleve, Difflam, etc.**
3. **If possible, the patient should avoid taking anti-inflammatory or blood thinning medication for at least 7 days. Products include ibuprofen, aspirin, etc.**
4. **The patient is advised not to smoke or drink alcohol for at least two hours before and after treatment.**
5. **If the patient can refrain from the use of make-up that day this will also help the skin to cool naturally.**
6. **For 2 days following treatment, the patient should only use cleansing products that have been developed for sensitive skin. Be gentle when drying or rubbing the area treated.**
7. **The patient should avoid tanning beds or sunbathing for at least 7 days after the treatment.**
8. **If the patient is unsure about any after effects following treatment they should contact the clinic for further advice.**

Patient Signature _____ Date _____

Witness _____ Date _____

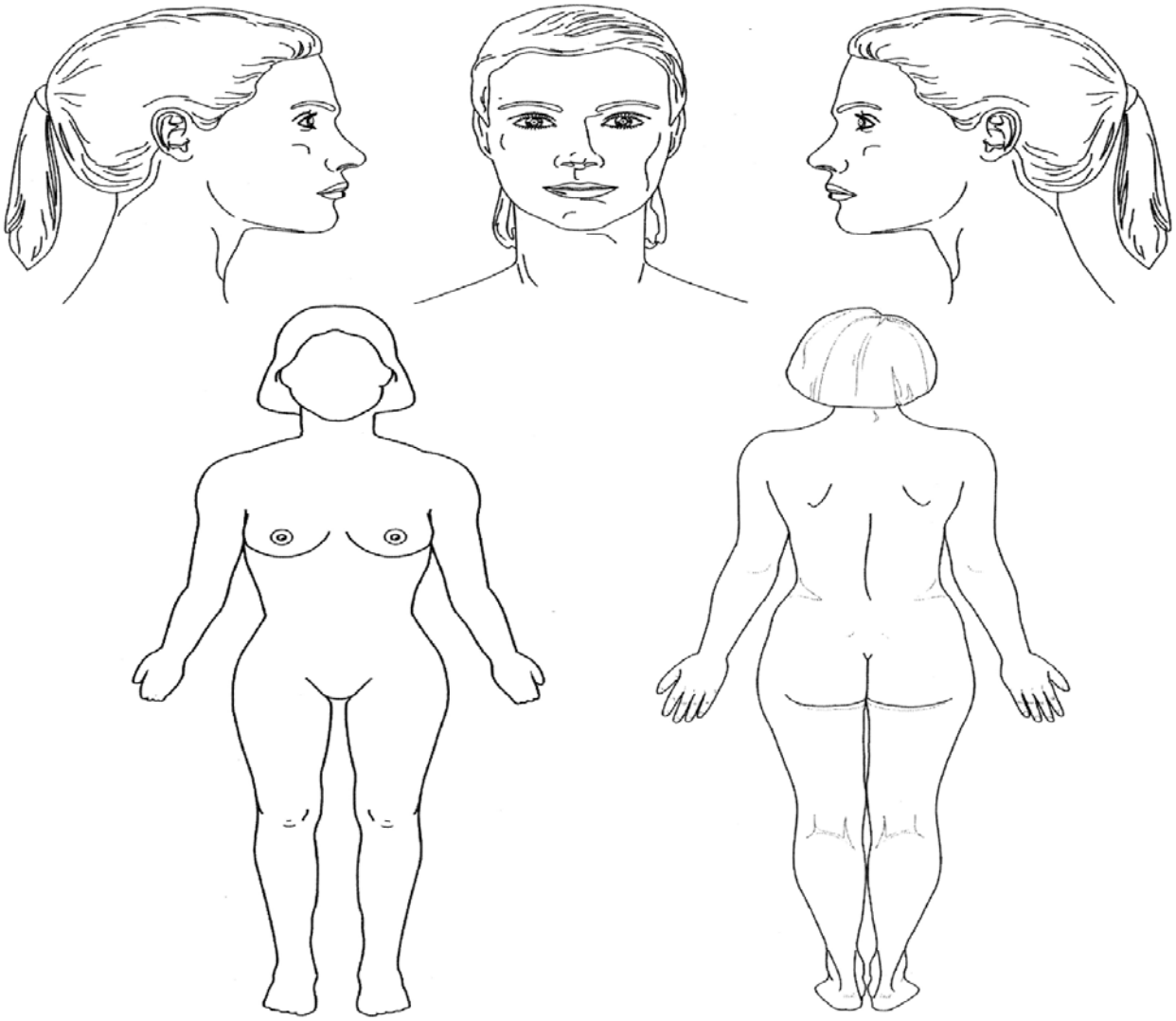
Anatomical Location for Hair Removal



Patient Name:

Patient Name:	Consult Date:
Treatment Date & Area:	
1st:	5th:
2nd:	6th:
3rd:	7th:
4th:	8th:

Anatomical Location for Hair Removal



Patient Name:

Patient Name:	Consult Date:
Treatment Date & Area:	
1st:	5th:
2nd:	6th:
3rd:	7th:
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