Ultimate Image MedSpa

eMatrix Consent Form

Client name _____

Treatment site: _____

I duly authorize Ultimate Image MedSpa to perform Sublative RF Treatment.

I understand that the Sublative RF is a device used for dermatological procedures requiring ablation and resurfacing of the skin, and for the treatment of facial wrinkles, of which I am consenting to be a patient receiving treatment. _____ (client's initials).

I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre- and post-treatment instructions, and individual response to treatment. _____ (client's initials).

I understand that there is a possibility of short-term effects such as reddening, swelling, scab formation, temporary discoloration of the skin, as well as the possibility of rare side effects such as burns, scarring, and permanent discoloration. These effects have been fully explained to me. _____ (client's initials).

I understand that there is a 30 minute numbing process prior to the treatment. The numbing process will vary based on my individual needs. It will involve a topical numbing cream and/or an ice pack. _____ (client's initials).

I understand that treatment with the Sublative RF involves a series of treatments, and the fee structure has been fully explained to me. I also understand there is a non-refundable $50 fee for the SpaKinect medical approval required for this service. _____ (client'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 have informed the staff regarding any current or past medical condition, disease or medication taken, as well as my past and planned exposure to sun, tanning beds, and tanning creams.

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 _____ (client's initials).

Client Signature_____ **Date**_____

Technician Signature_____ **Date**_____

Ultimate Image
MedSpa

Cancellation and No-Show Policy

Your treatment schedule is very important to us. We make every effort to keep all clients within the proper time frame for optimum results, however, we understand that life happens, and you may need to reschedule. In consideration of others, we **require** at least 24 hours of notice for cancellations.

Late arrivals: We will do our best to accommodate. Rescheduling will be necessary if our schedule cannot permit the time.

We are available via phone at 972-800-2127 during our business hours OR you may submit your request to info@UltimateImageSkincare.com

Late Cancellation Fee: Clients who cancel their appointment on the same day will be charged **$35.**

No Show Fee: Clients who completely miss their appointments without giving us any prior notification or cancellation at the time of the appointment will be charged **$50** or lose the scheduled service.

~~~ ALL SALES ARE FINAL ~~~

I have read and understood all the information presented above.

Client Signature: _____ Date: _____