PicoWay™

PICOWAY CONSENT FORM

CLIENT INFORMATION

NAME: ____________ GENDER: ____________ DOB: ____________

MEDICAL HISTORY:

Please answer the following questions:	YES	NO
Do you have **ANY** current or chronic medical illnesses? *Disclose any history of heat urticaria， diabetes, autoimmune disorders or any immunosuppression, blood disorders,cancer, bacterial or viral infections, medico conditions that significantly compromise the healing response , skin photo-sensitivity disorders, or any other condition or illness.* Please List:		
Do you have **ANY** current or chronic skin conditions? *Also disclose any history of vitiligo, eczema, mefosma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Dan/as syndrome. sc/eroderma, skin cancer, or any other skin condition.* Please List:		
Are you currently under a doctor's care? If so, for what reason?		
Do you take/use **ANY** medications (prescriptions and non prescriptions) , vitamins, herbal or natural supplements, on a regular or daily basis? Please List:		
Are there **ANY** topical products(both medical and non-medical) that you use on your skin on a regular or daily basis? Please List:		
Do you take/use **ANY** systemic/oral steroids(e.g..prednisone, dexamethasone) ?		
Do you have **ANY** allergies to medications.foods, latex or other substances? Please List:		
Are you receiving or have you received gold therapy? (rheumatoid arthritis)		
(For women) are you or could you be pregnant?		
(For women) are your menstrual periods regular?		
(For women) have you ever been diagnosed with Polycystic Ovarian Disorder?		
Do you have a history of **Herpes** I or II in the area to be treated?		
Do you have a history of **Keloid** scarring or **Hypertrophic** scar formation?		
Do you have a history of light Induced **Seizures**?		
Do you have **ANY** open sores or lesions?		
Do you have **ANY** history of radiation therapy in the area to be treated?		

PicoWay™

MINTSKIN

PICOWAY CONSENT FORM

MEDICAL HISTORY (CONT)

In the last six(6) months, have you used **ANY** of the following: *anticoagulants or blood-thinning medications; photo-sensitizing medications; anti-inflammatory medications* Please List product name and date last used:		
In the last three(3) months, have you used **ANY** of the following products: *glycolic acid or salicylic acid; alpha hydroxy or beta hydroxy acid products;* Please List product name and date last used:		
In the last three(3) months, have you used **ANY** exfoliating or resurfacing products or treatments? Please List product name and date last used:		
Do you have or have you ever had **ANY permanent make-up**, **tattoos**, **implants**, or fillers, including, but not limited to, collagen, autologous fat, Restylane B, etc. Please list locations on or in the body and dates:		
Do you have or have you ever had **ANY** Botulinums, such as Botox or Dysporf? Please list locations on or in the body and dates:		
Have you taken Accutane (or products containing isotretinoin) in the last 12 months?		
Have you taken Tretinoin (like Retin-A, Renova in the last 6 months?		
Have you had **Any** unprotected sun exposure, used tanning creams(including sunless tanning lotions) or tanning beds or lamps In the last 4-6 weeks?		

I have read carefully and confirmed that the information provided above is true and complete.

SIGNATURE: ______________________ DATE: ____________________

MINTSKIN

PicoWay™

INFORMED CONSENT
TATTOO REMOVAL

PLEASE READ BELOW AND TICK THE BOX

- The PicoWay laser produces an intense burst of light that is absorbed by the pigmented lesion or tattoo ink.
- All personnel in the treatment room,including me,will wear protective eyewear to prevent eye damage from this intense light.
- The sensation of the laserlight on skin is uncomfortable and may feel like as light pinprick or the sensation of heat.These sensations may last for a few hours.
- Tattoos may blister and have pinpoint bleeding for a few days after treatment.
- Following a pigment treatment,the treated areas maybe red,slightly swollen; pigment may darken and slough off in 7-10 days.
- The area should be treated delicately following treatment. Do not pick on cabbing/blistering.
- Multiple treatments maybe necessary.

I have been informed that hyperpigmentation(darkening of the skin) ,and hypo pigmentation(lightening of the skin) are possible complications of the procedure and incidence of this occurring are higher for darker skin types
☐ **YES** ☐ **NO**

I understand that sun exposure, as well as not adhering to the posttreatment instructions provided to me may increase my chance of complications.
☐ **YES** ☐ **NO**

I agree to have before and after pictures taken of the area to be treated
☐ **YES** ☐ **NO**

I have read and understood all information presented to me,and I have been given an opportunity to ask questions before signing this consent.
☐ **YES** ☐ **NO**

I have been informed that this treatment is non-refundable, and it can only be transferred to others if I cannot use it due to personal reasons.
☐ **YES** ☐ **NO**

I have read and understood all information presented to me,and I have been given an opportunity to ask questions before signing this consent.

SIGNATURE: ____________ DATE: ____________

MINTSKIN

PicoWay™

INFORMED CONSENT
FACIAL FOCUS TREATMENT

PLEASE READ BELOW AND TICK THE BOX

- The PicoWay laser using the Focus lens array produces an intense burst of light. All personnel in the treatment room, including myself, will wear protective eyewear to prevent eye damage from this intense light.
- Prior to the treatment, test spots maybe performed. Test spots help to determine effective treatment settings.
- The sensation of the laser light on the skin may feel like as light pinprick or the sensation of heat.
- The sensation of heat may last for an hour or longer after the treatment.Cold air or a cool gel pack maybe used during treatment or posttreatment to cool the skin and to minimize warmth.
- You will also hear as light snapping sound during the treatment and feel the touch of the laser distance gauge(part of the device) in the treated area.

POTENTIAL RISKS & COUNTERMEASURES

During treatment, there may be some risks in skin cosmetic treatment, and some uncommon risks may not be listed here (full face inflammatory reaction). The specific treatment methods vary according to the conditions of different patients. Questions about your skin beauty program can be discussed with the therapist.

- I understand that due to different personal aesthetic viewpoints and limited medical level, the skin beauty treatment effect may not fully meet the needs of customers
- I understand that after skin treatment, flushing, swelling, bleeding, scabs, purpura, and epidermal gasification may appear (including but not limited to) the treated area. Depending on the individual's age, physique, location and skin type, the recovery time varies
- I understand that skin treatment may cause hyperpigmentation (more common in deep pigmentation), hypopigmentation or depigmentation in the treated area. In the absence of drug intervention, the appeal situation can be metabolized within 1-3 months due to different personal physiques
- I understand that skin treatment may have a slower or inaccurate treatment effect. There are differences due to different medical conditions and different physiques.

POST-TREATMENT

- Cool the skin posttreatment as needed with cold gel packs, aloe vera gel, or cool air.
- Wash the treatment area gently with soap and water; do not soak the treated areas.
- Apply moisturizer for sensitive skin.
- Do not shave the treated area if crusting is evident
- Avoid sun exposure between treatments.If sun exposure is unavoidable, use a 30+ sunblock to protect exposed, treated areas
- For patients who are prone to breakouts or have sebaceous skin, consider waiting 24 hours before applying any topical products

I have been informed that hyperpigmentation(darkening of the skin) ,and hypo pigmentation (lightening of the skin) are possible complications of the procedure and incidence of this occurring are higher for darker skin types.

☐ **YES** ☐ **NO**

I understand that sun exposure, as well as not adhering to the posttreatment instructions provided to me may increase my chance of complications.

☐ **YES** ☐ **NO**

I agree to have before and after pictures taken of the area to be treated.

☐ **YES** ☐ **NO**

I agree that picoway treatment is valid for 1 year. I agree to treat on time / as prescribed by therapist to ensure the effect.

☐ **YES** ☐ **NO**

I have read and understood all information presented to me,and I have been given an opportunity to ask questions before signing this consent.

☐ **YES** ☐ **NO**

I have been informed that this treatment is non-refundable, and it can only be transferred to others if I cannot use it due to personal reasons.

☐ **YES** ☐ **NO**

I have read it carefully and understand all the information provided in the consent form, and I have the oppotunity to ask questions before signing this consent form.

SIGNATURE: ____________________ DATE: ____________________

MINTSKIN