DERMASOUND™ ULTRA

glymed+

Professional Treatment Consent Form

My signature below acknowledges that 1 have read the following and agree to receive treatments or a series of treatments listed below.

I hereby consent to, and authorize _____ , to perform DermaSound UltraSonic and micro amp treatments on me.

Areas to be treated: _____

Possible side effects include, but are not limited to: mild redness, moderate redness, mild breakouts, stinging, tenderness, dry skin, flaking, lightening or darkening of the skin. Most side effects are temporary and generally subside within 72 hours.

The nature and purpose of the DermaSound treatment has been explained to me, and any questions I have regarding this treatment have been explained to my satisfaction.

- I understand that with any treatment certain risks are involved and that any undesirable effects from known or unknown causes could occur. I freely assume these risks.
- I have been advised to avoid all injectable fillers including, but not limited to, collagen, Restalyne® as well as Botox® injections for a minimum of 14 days before any DermaSound ultrasound treatment and a minimum of 7 days after these injections and agree to these restrictions.
- I agree to adhere to all safety precautions and home skin care programs as recommended by my aesthetician.
- I am over 18 years of age or I have parental consent co-signed below.
- I do not have a pacemaker or any other electronic device in my body.
- I will call to inform my skin care professional immediately of any concerns if they should occur.

Please Initial:

_____ I am not pregnant.

_____ I agree to avoid direct sun exposure for 48 hours.

_____ I agree to apply sun protection cream daily.

_____ I agree to remove all jewelry during the treatment.

_____ I have not taken Accutane within 6 months.

_____ I do not have a pacemaker or any other electronic device in my body.

_____ I agree to follow the GlyMed homecare protocol.

_____ I agree to notify my skin care professional immediately of any concerns if they should occur.

_____ I agree to remove all jewelry before the treatments.

_____ I agree to avoid all injectable fillers and Botox® injections for a minimum of 14 days before any DermaSound ultrasound treatment and a minimum of 7 days after these injections.

Client Signature: _____ **Date:** _____

Parental Signature: _____ **Witness:** _____

800.676.9667 • info@glymedplus.com • glymedplus.com

PHOTO-AGING DERMATOLOGY

glymed+

Professional Treatment Consent Form

Patient Profile:

Name: _____ Age: _____ Sex: F M

Areas of Concern: _____

SPT: 1 1.5 2 2.5 3 3.5 4 4.5 5 5.5 6

Ethnic Background: _____ Lancer Ethnicity: _____

Medical History/Cosmeceutical Interaction

Health Complications: _____

Current Medications: _____

Allergies: _____

Previous Cosmetic Procedures: _____

Pregnant: _____ Nursing: _____ Planning: _____

Mother started menopause: _____ Contact Lenses: _____

Lifestyle and Stress

Occupation: _____ Since: _____

Sun Exposure Daily: _____ Yearly: _____ Lifetime _____ Next two weeks: _____

Daily SPF: _____ Smoker: _____ How long: _____

Alcohol consumption weekly: _____ Exercise: _____

Diet: _____

Daily water consumption: _____ Pets: _____

Stress Level: 1 2 3 4 5 6 7 8 9 10

How long: _____

Notes/Concerns:

Current Skin Care

STEP	DRUGSTORE	DEPARTMENT	PROFESSIONAL	RX
Cleansing				
Bleaching				
Acne Product				
AHA				
Retin-A				
Exfoliant/Type				
Treatment				
Moisturizing				
In-Clinic Treat				

Subdermis Thickness (*circle all that apply*):

thin med thick

Photodamage (*circle all that apply*):

Elastosis	mild	moderate	severe
Wrinkles	mild	moderate	severe
Wrinkles	Location–sun induced: _____		
	Location–smoking: _____		
	Location–repetitive movement: _____		

Texture (*circle all that apply*):

smooth rough irritated dry oily resistive sensitive telangietasia actinic keratoses

Pigmentation

Location: _____

Cause: _____

Acne (*circle all that apply*):

Chronic Acute Grade I II III IV

Skin care recommended: Essentials Kit: _____

Cleanse: _____ **Treat:** _____ **Balance:** _____ **Protect:** _____

Next Appointment: _____

800.676.9667 • info@glymedplus.com • glymedplus.com

PROFESSIONAL EXFOLIATOR + CHEMICAL SOLUTION CONSENT

glymed+

Professional Treatment Consent Form

Clinic/Spa: _____

Patient Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Cell:** _____ **Email:** _____

Clinical Treatment (*check all that apply*):

- ☐ Professional Pumpkin Exfoliator
- ☐ Professional Peptide Perfection Exfoliator
- ☐ Professional Exfoliator with 30% AHAs
- Professional Exfoliator
  - ☐ with 30% Lactic Acid
  - ☐ with 50% Lactic Acid
- ☐ Professional Oxygen Regenerative Solution
- Professional Solution
  - ☐ with 20% Salicylic Acid
  - ☐ with 30% Salicylic Acid
- ☐ Professional Jessner Solution
- ☐ Professional 5 Berry Solution with 7% TCA
- ☐ Professional Vitamin A Solution with 10% TCA
- ☐ Professional Pigment Lift Solution with 15% TCA
- ☐ DermaSound™ Ultra

GlyMed Plus® advises the treatment you will receive is ONLY available through a licensed and trained skin care professional.

GlyMed Plus® Purely Professional clinical treatments are immediately effective and produce long-term results when all directions, as advised by GlyMed Plus® and your licensed skin care professional, are adhered to. These special noninvasive skin performance treatments remove the outer layers of micro damaged skin—signaling new cells to emerge, increasing collagen, elastin and hydration levels thereby producing clearer and more younger looking and acting skin. Additional benefits may include the drying of active acne, dislodging or purging of blackheads, reduction of superficial wrinkles or scarring, improving the appearance of mature or aging skin, correcting sun damage, lightening pigmentation disorders such as sun or age spots, and controlling the effects of other health and aging skin challenges.

COMPLIANCE in your skin care program will determine the level of success and outcome of your treatment. Effective, long term results are dependent upon you. Consistency with your recommended continuance of GlyMed Plus® home skin care products exclusively as prescribed by your licensed skin care professional cannot be emphasized enough.

It is strongly advised you continue your professional in-clinic appointments as scheduled. Report any changes in health, diet, lifestyle or any reactions to your esthetician or physician. Apply sunscreen as directed by your esthetician or physician, avoid excess sun exposure and avoid tanning beds. Inform your esthetician or physician of any recreational plans for the week following your treatment.

No guarantee is made or implied regarding results, treatment times or level of discomfort. Your treatment may involve the application of several exfoliators or solutions at one, two or four week intervals, as determined by your esthetic/professional technician. It may include the use of GlyMed Plus® skin brightening agents and sun-protection products. GlyMed Plus® advises a patch test (usually requiring a nominal fee) applied behind the ear to gauge possible reactions.

Depending on your treatment, you may experience some temporary discomfort, including stinging or warm flushing, similar to a mild burning sensation. This is NORMAL and generally fades within five minutes. During the few minutes following the initial treatment, you will experience tightening of the skin to varying degrees. The skin can appear red and become progressively rosier, occasionally turning a tan to brown color, depending upon formula and application variances.

For most individuals, peeling starts at day five but can be as early as 48 hours. It is impossible to pre-determine how much peeling will occur. Deeper penetration and more active solutions may result in sensitivity for several hours after the procedure, with some significant peeling for up to ten days. Your skin can feel tight, dry and you may experience redness for up to ten days.

To enhance your treatments and relieve discomfort for the period following your treatment, you are advised to do the following:

- Drink a full glass of tepid water immediately after treatment and a total of eight glasses in the following eight hours.
- Use only professional skin care products recommended by your esthetician or physician.
- Notify your esthetician or physician of ANY concerns.
- Do not use tanning beds, and avoid sun exposure as much as possible. Apply sunscreen DAILY.

Steps to remember post-peel:

- Avoid all sun exposure.
- Avoid exercise and sweating for 48 to 72 hours.
- Avoid having the shower spray directly on the face.
- Do not pick, rub, or unnecessarily touch the face.
- Minimize facial expression.
- Sleep on back.
- Shampoo with head tilted backward to avoid shampoo on skin.

I herby give my voluntary consent and authorization for treatment and release the above named provider, its employees, associates and subsidiaries and GlyMed Plus® LLC. I release its employees, associates and subsidiaries, from any claims expressed or implied that I have or may have in the future, in connection with this treatment regardless of result. By signing, I am stating I fully understand the above and that the treatment had been explained to me in detail.

Signature: _____ **Date:** _____

800.676.9667 • info@glymedplus.com • glymedplus.com

SKIN HEALTH QUESTIONNAIRE glymed+

Professional Treatment Consent Form

Client should complete the following, as directed, as thoroughly and in as much detail as possible.

Name			Date
Daytime Phone		Evening Phone	
Street Address			City
State	Zip	Email	
Birthdate	Emergency Contact		Relation to Contact
Your Physician		Phone Number	
How did you hear about us?			Occupation

Interest

Please indicate which services you are interested in:

☐ Skin Care Consultation/Advice ☐ Home Care Products	☐ ClinicalTreatments ☐ Age Management	☐ Acne Treatment/ Management ☐ Rosacea

☐ What do you wish to change about your skin?

Medical History

Are you currently, or have you previously experienced any of the following:

☐ Heart condition	☐ Cancer	☐ Hemophilia	☐ Herpes Simplex
☐ Pacemaker	☐ Thyroid condition	☐ Asthma	☐ AIDS/HIV Positive
☐ Headaches	☐ Kidney problems	☐ Diabetes	☐ Autoimmune
☐ Anemia	☐ High blood pressure	☐ Hypo/Hyper glycemia	Type_____
☐ Low blood pressure	☐ Arthritis	☐ Hepatitis	Contact Lenses

If you are currently experiencing or being treated for any health-related condition, please describe:

Have you ever had surgical or non surgical procedure? If yes, where on your body was the surgery performed?

Do you have any allergies? Also list any skin treatment products you have used that caused an unexpected reaction or side-effect:

Please list all over-the-counter and prescription medications you are currently taking:

Please indicate if you have ever used any of the following medications for skin treatment:

☐ Accutane	☐ Retin A	☐ Fosdex	☐ Renova
☐ Cortisone	☐ Sulfer	☐ Glycolic Acid	☐ Clindamycin
☐ Staticin	☐ DesquamX	☐ Salicylic Acid	☐ Tazoratene
☐ Benzoyl Peroxide	☐ Zerac	☐ Lactic Acid	☐ Metrogel

What condition were you treating with this medication(s)?

When was the last time you used these medications?

Women

Are you pregnant? Yes No

Are you planning a pregnancy in the near future? Yes No

Are you currently on any type of hormone therapy? If yes please describe:

Do you have regular periods? Yes No Are you going through menopause? Yes No
Do you have any hormone imbalance? Yes No
Have you undergone surgical menopause (hysterectomy) Yes No When?

Skin Self-Analysis

What skin care products are you currently using?

Are you wearing a daily sunscreen? Type: SPF:

Is your skin: ☐ Oily or acne prone? ☐ Dry? ☐ Normal? ☐ Sensitive?

Have you ever treated or been treated for a skin condition? If yes, what condition?

How did you treat the condition:

☐ Dermatologist ☐ Aesthetician Self treated with products purchased from: ☐ Drug Store ☐ Department Store

Were you happy with the result? Yes No

Are you currently treating or being treated for any skin condition?

Lifestyle and Stress Analysis

Do you come in contact with any chemicals at work? Do you work around excessive heat or cold?

Do you use Personal Protective Equipment (PPE*)? If so, what type and for how long? *Masks, gloves, shields, etc.

How often do you exercise? Average hours of sleep? What is your stress level?

How many minutes a day are you exposed to sunlight?	How many hours a week do you use a tanning bed?
Do you get cold sores?	What is your ancestory? Father Mother

Please indicate any of the following that apply to your eating habits:

☐ Fast food	☐ Salt your food	☐ Dairy products	☐ Peanut Butter
☐ Baked Bread	☐ Seafood	☐ Ethnic or Spicy foods	☐ Peanuts

How much water do you drink per day? Caffeine? Carbonated drinks?

Do you smoke tobacco products? Average alcohol consumption per week?

Have you changed your brand of skin care products in the last year? If yes, why did you change?

I understand and agree that I am ultimately responsible for payment in full for services recieved.

Signature of Patient or Responsible Party:_____

Date: _____ **Relationship to Patient:** _____

800.676.9667 • info@glymedplus.com • glymedplus.com

TAKE + PUBLISH PHOTOS/VIDEOS

glymed+

Professional Treatment Consent Form

Name: _____

Place: _____ **Date:** _____

This authorization grants permission to use your image (still or moving) and/or your spoken words in perpetuity for educational purposes.

By signing this document, you agree:

01 To allow the recording of your image and voice (e.g., photographs, audio, or video).

02 To distribute your image or recording in any medium, be it print or electronic form, which may include the Internet.

03 To grant permission to other entities to reproduce the images or recording for educational purposes.

04 That there is no reimbursement for the right to take, or to use your photograph or video or recording.

Nature of image and/or spoken words to be recorded:

_____

_____

Purpose of recording, image and/or spoken words, including the intended audience:

_____

_____

I have read and fully understand the intent and purpose of this document, and I am signing it without reservation.

Signature: _____ **Witness:** _____

800.676.9667 • info@glymedplus.com • glymedplus.com

UPDATED CLIENT TREATMENT RECORD

glymed+

Professional Treatment Consent Form

Client Name: _____ **Date:** _____

Please note any changes since last visit to the following:

Address: _____ Contact Information: _____

Health: _____ Medications: _____

Skin Care Products: _____ Hormones (women only): _____

In the last 5 days have you...

Had any waxing or depilatories on your face	Y	N	When _____
Had any excess exposure to the sun	Y	N	When _____
Been in a tanning bed	Y	N	When _____
Been ill	Y	N	When _____
Had any surgical/aesthetic procedures	Y	N	When _____

In the last 24 hours have you...

Exercised	Y	N
Used Retin A	Y	N
Had unusual stress	Y	N

What are your plans for the rest of the day?

What are your plans for the next 7 days?

Signature: _____ Date: _____

Treatment (Aesthetician Notes)

- ☐ Professional Pumpkin Exfoliator
- ☐ Professional Peptide Perfection Exfoliator
- ☐ Professional Exfoliator with 30% AHAs
- • Professional Exfoliator
  - ☐ with 30% Lactic Acid
  - ☐ with 50% Lactic Acid
- ☐ Professional Oxygen Regenerative Solution
- • Professional Solution
  - ☐ with 20% Salicylic Acid
  - ☐ with 30% Salicylic Acid
- ☐ Professional Jessner Solution
- ☐ Professional 5 Berry Solution with 7% TCA
- ☐ Professional Vitamin A Solution with 10% TCA
- ☐ Professional Pigment Lift Solution with 15% TCA

Time/Layers: _____ Result: _____

Home Care Products:

Cleanse: _____ Treat: _____ Balance: _____ Protect: _____

Instructions for Use: _____

Next Appointment: _____ **Time:** _____

800.676.9667 • info@glymedplus.com • glymedplus.com