JET PLASMA PEN

Medical/Treatment History:

- **Do you have a Pacemaker?** ❑ No ❑ Yes
- **Do you have an implanted Neurostimulator?** ❑ No ❑ Yes
- **Do you have any electrical implanted device or implanted slow medication release?** ❑ No ❑ Yes
- **Are you pregnant or is there any possibility you could be pregnant?** ❑ No ❑ Yes
- **Have you had Botox or filler in the past 2 weeks?** ❑ No ❑ Yes

Please initial/sign where indicated below:

I understand that JET Plasma requires multiple sessions. It is recommended a minimum of 3 sessions (up to 8) for best results. (initial) _____

I understand there are no guarantees as the the results of the is treatment, due to many variables such as age, condition of the skin, smoking, home-care etc... (initial) _____

I understand that the taking of Before & After photographs is a condition of the procedure and grant permission for the use of the photographs, or electronic media images as identified, in any presentation of all kinds. (initial) _____

If anything changes in my medical condition/history during the course of my treatments, it is my responsibility to inform my nurse and/or aesthetician. (initial) _____

Although aftercare is minimal with this procedure, it has been explained to me and I have been given written instructions to take home with me. (initial) _____

Patient Signature:_____ Date:_____

Clinician Signature:_____ Date:_____