



**JOHNSONS**  
FAMILY MEDICINE  
& AESTHETICS



# OPTIMAS MAX INTAKE FORMS

LUMECCA PEAK (IPL)/DIOLAZE XL (HAIR REMOVAL)/MORPHEUS 8 BURST

## 2.1.1 PERSONAL INFORMATION

NAME		HOME PHONE	
ADDRESS		MOBILE PHONE	
CITY		STATE	
ZIP CODE		DATE OF BIRTH	
REFERRED BY		GENDER	

## 2.1.2 SKIN TYPE OF ASSESSMENT

FITZPATRICK SKIN TYPE	I II III IV V VI	ETHNICITY	
F TYPE LAST EXPOSED TO UV.	(SUN OR TANNING BED)		
PASSIVE TAN?	YES / NO	SELF-TANNING LOTION?	YES / NO

## 2.1.3 HAIR ASSESSMENT

AREAS TO BE TREATED			
HAIR DENSITY	SPARSE / MEDIUM / DENSE	HAIR THICKNESS	FINE / MEDIUM / COARSE
HAIR COLOR		HAIR DENSITY	_____ / CM2

## 2.1.4 MEDICAL HISTORY

PACEMAKER/DEFIBRILLATOR OR			
METAL IMPLANTS		ACTIVE SKIN INFECTION (E.G., PSORIASIS, ECZEMA)	
CURRENT OR HISTORY OF SKIN CANCER/ OTHER CANCER / PRE- MALIGNANT MOLES/SUSPICIOUS LESIONS		SKIN DISORDERS/CONDITIONS (E.G., KELOIDS, ABNORMAL WOUND HEALING, VITILIGO)	
SEVERE CONCURRENT MEDICAL CONDITIONS (E.G., CARDIAC DISORDERS)		USE OF MEDICATION/HERBS INDUCING PHOTSENSITIVITY	
PREGNANCY OR NURSING		LASER RESURFACING / DEEP CHEMICAL PEELING, LAST 3 MONTHS	
IMPAIRED IMMUNE SYSTEM		NEEDLE EPILATION, WAXING, OR TWEEZING, LAST 6 WEEKS	
DISEASES STIMULATED BY LIGHT (E.G. LUPUS, PORPHYRIA, EPILEPSY)		CURRENT OR PAST HISTORY OF GOLD THERAPY	
INTRA-DERMAL OR SUB-DERMAL INJECTIONS/FILLERS/GRAFTS		TATTOO, PERMANENT MAKEUP OR TANNED SKIN	
DISEASES STIMULATED BY HEAT (E.G. HERPES SIMPLEX)		HISTORY OF BLEEDING DISORDERS	
ENDOCRINE DISORDERS (E.G., DIABETES, PCOS)		SAPHENOUS INSUFFICIENCY SEVERE VARICOSITY	
<b>SURGICAL PROCEDURES</b>			
<b>Current Medications</b>			
<b>List any Allergies</b>			
<b>Detail any Medical Condition.</b>			
<b>Other Considerations</b>			

# OPTIMAS MAX INFORMED CONSENT

## LUMECCA PEAK (IPL) OR DIOLAZE XL (Hair Removal)

PATIENT NAME \_\_\_\_\_

TREATMENT SITES \_\_\_\_\_

I DULY AUTHORIZE \_\_\_\_\_ TO PERFORM \_\_\_\_\_ TREATMENT.

I understand that the device is being used for Laser Hair Removal, Vascular Lesion Clearance, Skin Rejuvenation, Fractional Skin Resurfacing, and Skin Tightening, and I am consenting to be a patient receiving \_\_\_\_\_ treatment (specify procedure).

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.

I understand that there is a possibility of short-term effects such as reddening, mild burning, temporary bruising, and temporary discoloration of the skin, as well as the possibility of rare side effects such as scarring and permanent discoloration. Hair removal by lasers can cause temporal increased hair growth in some individuals. These effects have been fully explained to me \_\_\_\_\_ (patient's initials).

I understand that treatment with this system involves a series of treatments, and the fee structure has been fully explained to me \_\_\_\_\_ (patient'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.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

I agree to waive, release, discharge, and covenant not to sue Invasix, Inc. d/b/a InMode ("InMode") and its employees, agents, and representatives from any liability, loss, cost, damage, expense, claim, or lawsuit whatsoever for any and all injury, loss, illness, harm, cost, expense, or damage related to the treatment, including any negligent acts or conduct by InMode and its agents, employees, and/or representatives (collectively, "Claims").

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.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

# OPTIMAS MAX INFORMED CONSENT

## MORPHEUS 8 BURST RF MICRO-NEEDLING

PATIENT NAME \_\_\_\_\_

TREATMENT SITES \_\_\_\_\_

I DULY AUTHORIZE \_\_\_\_\_ TO PERFORM \_\_\_\_\_ TREATMENT.

I understand that the device is being used for Subdermal and dermal remodeling of facial and body areas through fractional coagulation and sub-necrotic bulk heating, and I am consenting to be a patient receiving Morpheus8 treatment.

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.

I understand that there is a possibility of short-term effects such as reddening, mild burning, temporary bruising, and temporary discoloration of the skin, as well as the possibility of rare side effects such as scarring and permanent discoloration. When using Morpheus8, there is a potential low-level stimulation of branches of the facial nerve, and involuntary contraction of the underlying facial muscle may occur. This is transient and is not harmful, as the Morpheus8 effect diminishes at the deeper level, where parts of the facial nerve lie above the muscles. These effects have been fully explained to me \_\_\_\_\_ (patient's initials).

I understand that treatment with this system involves a series of treatments, and the fee structure has been fully explained to me \_\_\_\_\_ (patient'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.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

I agree to waive, release, discharge, and covenant not to sue Invasix, Inc. d/b/a InMode ("InMode") and its employees, agents, and representatives from any liability, loss, cost, damage, expense, claim, or lawsuit whatsoever for any and all injury, loss, illness, harm, cost, expense, or damage related to the treatment, including any negligent acts or conduct by InMode and its agents, employees, and/or representatives (collectively, "Claims").

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.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_



