Cryotherapy Treatment Consent

Clinic/Salon	
Client's Name	
Address	
Email	
Telephone Number	

To the client:
It is important that you are informed about your skin condition and proposed treatment including the potential benefits and risks involved.
This disclosure is not meant to scare or alarm you; it is simply an effort to better inform you so that you may give or withhold your consent to the treatment.
I__________________________________of (address as above) have requested Cryotherapy to remove my benign skin lesion (i.e. skin tag, skin wart, brown spots, milia, cherry angioma, verrucae).

Please tick to confirm that you have read and understood the following statements.	INITAL
Any concerns that the skin imperfections is anything other than benign I have cleared and approved by a medical practitioner prior to this treatment.	
I confirm that I do not Keloid scar.	
I confirm that I am aware of the contra indications relevant to a treatment with Cryotherapy.	
I confirm that I have been given the aftercare for treatments with a Cryotherapy.	
I confirm that I have read and been advised of the risks involved in such treatment, the expected benefits of such treatment, and alternative treatments, including no treatment at all. (Please see over the page).	

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and that I have had sufficient opportunity for discussion and to ask questions. I consent to this procedure today and for all subsequent treatments.

Nurse Name				
What did you treat?				
How many seconds?				
Freeze/Thaw Cycle				
Clients Signature		Date		
Nurse Signature		Date		

PLEASE TAKE THE TIME TO READ THIS CAREFULLY AND TO UNDERSTAND ANY ACCOMPANYING INFORMATION

This form is an example provided by Cryosthetics. it is up to the provider of the service to legalities of consent forms which suit their business. Provider of this service has been informed by Cryosthetics of local laws which may apply to the operator and hold no responsibility for treatment outcomes. Results may vary. Use only as directed.

Risks and side effects:
Cryotherapy is relatively low-risk treatment and side effects and complications are usually minimal.

Some side effects may occur as a result of the treatment. These include:

- Headaches are not uncommon when freezing on the forehead, scalp and temples and can last for 2 hours.
- Pigment changes. Both hypo pigmentation (lightening of the skin) and hyper pigmentation (darkening of the skin). Both generally last a few months but can be longer lasting.
- Nerve damage. Though rare, damage to nerves is possible, particularly in areas where they lie closer to the surface of the skin, such as the fingers, the wrist, and the area behind the ear. Reports suggest this will disappear within several months.
- A Blister may appear in the treated area and can last anything from a few hours to a few days, dependent on the area to be treated.
- Shards of frozen ice. The innovation of Cryotherapy is the direct application of carbon dioxide under high pressure (55 bar). This high pressure jet may cause minor shards of frozen ice in the air blown away in a circle of approximately 30cm. They will thaw the moment they would eventually touch healthy skin.
- Treatments on sites with coarse terminal hair. Hair follicles are easily damaged by cryosurgery and permanent alopecia is not uncommon.

Please now tick on your treatment consent to show that you have read and understood the possible risks from a cryotherapy treatment. It is recommended to use a factor 50 to protect treated areas. Ask your clinic about Cryobloc.

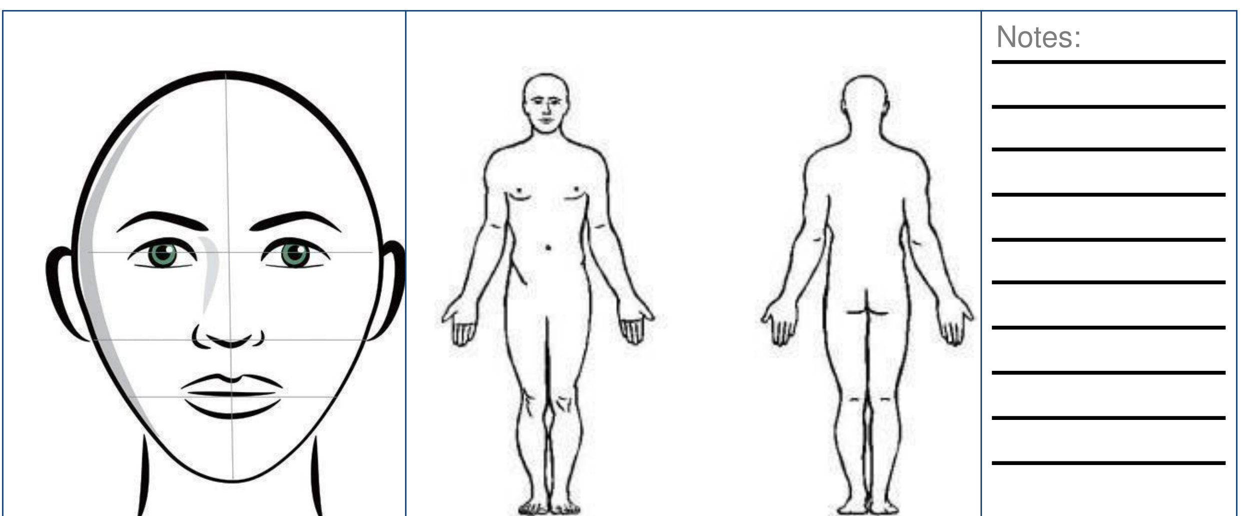
Do ask your therapist any questions if there is anything that you are unsure about.

TREATMENT MODEL CONSENT

Photography / Video Release
TREATMENT MODEL CONSENT FORM
As part of your treatment we will be photographing the treatment area of your body/face (and in some cases, filming the treatment process). This will allow us to visually monitor your individual progress and see the results of your treatment over time. We would appreciate your willingness to share your outcomes and results with others, for both training and marketing purposes within the beauty, cosmetic and aesthetic industry. In all cases we will do everything we can to keep your identity anonymous.
With this form I, (insert participant's name) ....
give my full consent for all photographs/footage captured before, during and after my treatment by, (insert clinic/practice name).. to remain the property of the clinic and the aesthetic equipment supplier Cryosthetics.
With this consent, I give permission for the images/footage (if they are to be selected) to be used in the following and similar materials :(Please tick one or both preferences)

- Marketing and advertising for either the clinic or Cryosthetics, to be used on company websites
- In-clinic waiting room materials or other such industry media channels. Examples are Product/ treatment brochures, clinic advertising material and information made available to other clients interested in the treatment.
- In training purposes, educational material for the clinics, Cryosthetics and internal use only. Such as user product manuals, educational charts and industry communications

Signature		Date	



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