

With all of the aesthetic and cosmetic options, we are pleased that you have selected the service of Allure Medical. We are certain you will find that our standards and personalized patient care rank among the best in the industry. Please review the following information regarding your treatment. Remember that our staff is more than happy to answer any questions that you may have. Finally it is our pleasure to welcome you to Allure Medical.

NOTICE OF CONFIDENTIALITY

I understand that Allure Medical will retain my treatment records for a full 3 years after treatments cease. During this time, all personnel at Allure Medical including the physicians, nurses and aesthetician will have complete access to my records. However, no third party shall receive copies of my records without my specific written consent. Only under appropriate medical review may any information regarding my treatment be released and studies to further ensure the efficacy and safety values of Allure Medical. I understand that Allure Medical may ask to photograph the area being treated to document and track the results. And Allure Medical will always use the utmost discretion while taking such photographs and will never release them without my full knowledge and expressed written consent.

MEDICAL HISTORY DISCLOSURE

Allure Medical wants to provide me with the utmost level of care. Thus, I am aware of the importance of disclosing my complete, personal medical history. I will notify Allure Medical of any changes in my healthcare as they occur during my treatment process. In addition, I will also inform Allure Medical of all medications that I currently take, including but not limited to: prescriptions and over-the-counter drugs, herbs, supplements, vitamins and birth control. I understand that any failure to do so on my part may result in an increase in the likelihood of side effects or complications post treatment.

POSSIBLE RISKS AND SIDE EFFECTS

I am completely aware of and have no further questions regarding possible side effects and risks associated with my treatment. I understand that these include but are not limited to: pain, scaring, bruising, swelling, redness, pupura, blistering, hyperpigmentation and hypopigmentation. I understand that treatments are usually sold in packages to achieve maximum results and that a single treatment may not be sufficient to provide the desired effect. Furthermore, I understand that individual results may vary according to the following factors: skin type, area of body being treated, natural hair color, post-treatment care, follow-up care and tanning by sun-exposure or self-tanning products. I will minimize these risks by adhering to the post-treatment care instructions give to me by the staff at Allure Medical.

CLINIC POLICIES

- * I understand that there will be no refunds for any treatment, product, services or gift certificates.
- * I understand that if I fail to provide 24-hour notice of cancellation, I will be billed for the service as scheduled.
- * I understand that treatments are not covered by insurance and that payment is due at the time service is rendered.
- * I understand that this signed consent form shall remain effective through my continuity of care on behalf of Allure Medical. This is in regard to the treatment that I shall receive today and any future treatments or services rendered to me by Allure Medical.

My signature below attests to the fact that I fully understand and accept all of the above information. I have had answered any questions pertaining to such. I certify that I am at least 18 years of age.

Printed Name

Date

Signature