LAURA McELROY
BEAUTY

401 E. 8th St. #224 (8th & RR) • Sioux Falls, South Dakota 57103 • (605) 370-1577 • www.lauramcelroybeauty.com

Client Profile/Medical History

Date: _____

Name: _____ DOB: _____ Age: _____ Sex: _____

Email: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

What procedure are you interested in? (please circle)

Depigmentation of Scarring Stretch Marks Hyperpigmentation Burns

Keloids/Hypertrophic Scarring Acne/Atrophic Scarring

What part of the body:

_____

What treatments have you done previously to help your scars?

_____

_____

Are you happy with those results? YES _____ NO _____

Explain: _____

_____

_____

How old are your scars? _____

Are you applying any topical medications at this time?

YES _____ NO _____ Which One(s)? _____

_____

Are you currently using any topical Retinoid prescriptions?

(Retin-A, Tretinoin, Renova, Differin, Tazorac, Avage?)

YES _____ NO _____ What Strength? _____ How Long? _____

Are you currently using Accutane? YES _____ NO _____ How Long? _____

Have you ever been on Accutane? YES _____ NO _____ When? _____

Do you get: (please circle if applicable)

Regular Chemical Peels Laser Resurfacing Tattoo Removal Collagen

Botox Other Dermal Filler Injections

Last Treatment Date(s):

_____

_____

Have you recently had surgery? YES _____ NO _____

Date of Surgery _____ Explain: _____

_____

_____

Are you pregnant or lactating? YES _____ NO _____

Do you smoke or use tobacco? YES _____ NO _____

Do you wear contact lenses? YES _____ NO _____

Do you participate in vigorous aerobic activity or sports?

YES _____ NO _____ What type? _____

_____

Do you develop cold sores/fever blisters? YES _____ NO _____

Last Breakout? _____

Allergies and/or Sensitivities: (please circle all that apply)

Citrus Grapes Dairy/Milk Apples Mushrooms Bees Aloe Vera

Aspirin Latex Perfumes Hydroquinone

Other Allergies? _____

Reactions? _____

Are you sensitive to alcohol-based products?

YES _____ NO _____

Have you ever used any other products that caused a reaction?

YES _____ NO _____

Describe: _____

_____

Are you taking any oral medication(s) at this time? (Antibiotics and Steroids increase sensitivity) YES _____ NO _____

Which one(s)? _____

_____

Are you taking any prescription and/or over the counter blood thinners? (Including, but not limited to: Aspirin, Ibuprofen, Vitamin E, Omega 3) YES _____ NO _____

Which one(s)? _____

_____

What is your ethnic background? (Please include all nationalities)

_____

_____

Natural Eye Color: (please circle)

Blue Green Hazel Gray Light Brown Dark Brown

Natural Hair Color: (please circle)

Blonde Red Light Brown Medium Brown Dark Brown Black Gray/Silver

Skin Tone: (please circle)

Pale/White Light Medium Red/Ruddy Freckled Sallow Light Olive

Medium Olive Dark Olive Light Brown Medium Brown Dark Brown

Soft Black Black

Do you consider your skin: (please circle)

Sensitive Resilient Unsure?

Do you tan? YES _____ NO _____ How Often? _____
Do you tan your face? YES _____ NO _____ How Often? _____

Describe your skin: (please circle all that apply)

Thick Thin Saggy Firm Normal Dry T-Zone/Combination Oily

Acne Comedones/Blackheads Milia Cysts Breakouts Acne Scarred

Large Pores Small Pores Red/Ruddy Rosacea Eczema Psoriasis

Freckled Sun Damaged Uneven/Blotchy Mature Fine Lines/Wrinkles

Patchy Dryness Sallow Melasma Hypopigmentation Hyperpigmentation

Dehydrated/Asphyxiated Broken Capillaries Perfume Stained

What have you done to treat your skin/scars/stretch marks? What products are you using?

_____

_____

_____

_____

What are the improvements you would like to see in your skin/scars/stretch marks?

_____

_____

_____

_____

***ALWAYS CONSULT YOUR PHYSICIAN BEFORE DISCONTINUING USE OF ANY PRESCRIPTION(S).

Treatment Recommendation: SEE TREATMENT PLAN

Patch Test: (please initial) Consented To _____ Waived _____

Guardian Signature (if under 18): _____ Date: _____

Client Signature: _____ Date: _____

Practitioner Signature: _____ Date: _____

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Scar Revision Contraindications

Contraindications for the Treatment:

- Liver Disease
- Cancer
- Serious Heart Disorders
- Blood Infections
- Pacemaker
- Metal Plates and/or Pins in the treatment area
- Epilepsy
- Sick with Flu, Fever, COVID etc
- HIV, Hepatitis, or any other bloodborne, communicable diseases and/or skin lesions
- Active dermatologic disorders, i.e. rosacea, eczema, psoriasis, acne
- Pregnant or Nursing
- Accutane (within 1 year)
- If under 18 Years of Age (Needs Parental/Legal Guardian Consent)

Requires Medical Clearance/Pre-Medication:

- Diabetes
- Medications, especially those pertaining to Mental Health and Chronic Acne
- Anemia
- Artificial Heart Valves, Heart Problems, Blood Problems

- Skin Disorder/Disease such as MRSA or Hidradenitis Suppurativa (Must be in remission)
- Skin Cancer (Must be through treatment and no evidence of skin cancer remaining)
- Receiving Medical Care
- Taking Prescription Blood Thinners
- Cancer in the Past 6 Months
- Poor health and healing
- Autoimmune Disease (this may be a “contraindication” depending on Doctor’s evaluation)

Requires a Waiting Period:

- Sunburned Skin
- Under the Influence of Drugs and/or Alcohol (Refrain from Alcohol for at Least 24 - 48 Hours)
- Allergies, Especially to Nickel or Topical Anesthetics. (Must do a Patch Test)
- Retinol or AHA Skincare Products within the Last 2 Weeks
- Retin-A, Laser, Microdermabrasion, or Chemical Peels within the Last 4 Weeks
- Botox, Fillers, or Collagen within the Last 8 Weeks if treatment is in the area of the filler.
- Permanent fillers such as shark cartilage, dermagen or fat injections within the last 16 weeks
- Active Cold Sores/Fever Blisters… must wait until the outbreak is over. It is mandatory to take an antiviral medication such as Valtrex the day before, on the day of, and for 4 days after the treatment if working on an area that has had herpetic activity.
- Taking Steroids or any other short term medications that thin the blood.

Other Conditions that may Affect the Healing Time, Color Retention (if applicable) and/or the Overall Results of the Procedure(s):

- Prolonged Bleeding
- Hair Loss
- High Blood Pressure
- Low Blood Pressure (May Experience Dizziness, Weakness, and/or Confusion)
- Hemophilia and other Bleeding Disorders

Other things to be aware of:

- Excessive fillings/braces will leave a strong metallic taste in your mouth
- Aspirin, Ibuprofen, Caffeine, Vitamin E, and Omega 3s will thin the blood
- Headaches/Migraines… High Frequency emits a buzzing sound
- All metal jewelry must be taken out/off before the treatment

Guardian Signature (if under 18): _____ Date: _____

Client Signature: _____ Date: _____

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Release and Consent

(Please Initial)

_____ I am over the age of 18.
_____ I am not under the influence of drugs and/or alcohol.
_____ I am not pregnant or nursing.
_____ I understand and accept that this treatment is a process, requiring monthly treatments as stated in the TREATMENT PLAN to achieve desirable results and 100% success cannot be guaranteed.
_____ I understand and accept that while healing, it is normal for the treatment area to look worse before it looks better.
_____ I have received, reviewed and understand the aftercare instructions as given to me and agree to follow them.
_____ I understand and accept that any other cosmetic/laser procedures are not to be done to the treatment area for the duration of time stated in the TREATMENT PLAN.
_____ If I have elected to go against the aforementioned agreement and go elsewhere to receive cosmetic/laser procedures on the treatment area during the duration of time stated in the TREATMENT PLAN, I assume any and all responsibility and agree there will be added costs to undo any damage that may have been caused.
_____ I realize this is an elective cosmetic procedure and is not medically necessary.

_____ It has been explained to me that the following possibilities may occur: Minor and temporary bleeding, bruising, redness or other discoloration, swelling, fever blisters on the lip area following procedures around the lip area.

_____ I give my consent to Laura McElroy Beauty, LLC to confer with my physicians for medical information required for the safety of my procedures.

_____ I agree to accompany my practitioner to the emergency room in the event they were to be accidentally stuck with my needle and take a blood test for their safety & disclose all test results to my practitioner.

_____ I am aware that if an infection occurs after I have received a scar revision treatment to see my primary physician or go to the emergency room, immediately.

_____ I have answered the client information truthfully to the best of my knowledge and agree to the TREATMENT PLAN as outlined by Laura McElroy of Laura McElroy Beauty, LLC.

ACCEPTANCE:

I have read and understand these risks listed above and they have been explained to me. I certify that the information in the above questionnaire is accurate and my questions have been answered.

***Please read all questions thoroughly before signing!

RELEASE:

I release Laura McElroy and Laura McElroy Beauty, LLC from any and all responsibility related to Permanent Cosmetics/Cosmetic Tattooing, Dry Tattooing/Skin Needling, Dermaplaning, Scar Revision/Scar Relaxation, Chemical Peels and/or any and all Esthetic Treatment(s) performed by Laura McElroy.

I hereby discharge Laura McElroy Beauty, LLC, Laura McElroy, her immediate family, relatives, heirs, associates, co-workers, instructional institutes and establishments where Laura McElroy and Laura McElroy Beauty, LLC conducts business from any and

all claims, demands, damages, actions or cause of actions arising out of treatment(s) performed. I accept the TREATMENT PLAN, color and design(s) if applicable, and payment terms as outlined by Laura McElroy accordingly.

Guardian Signature (if under 18): _____

Print Name: _____ Date: _____

Client Signature: _____

Print Name: _____ Date: _____

Practitioner Signature: _____

Print Name: _____ Date: _____

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Chemical Peel Consent

(Please Initial)

_____ Prior to receiving treatment, I have been candid in revealing any condition that may have a bearing on this procedure, such as: pregnancy (consult with and obtain a Doctor's written consent prior to treatment), recent facial surgery, allergies, cold sore/fever blister history, use of Retin-A, Tretinoin, Differin, Tazorac, Avage, or Accutane.

_____ I understand there may be some degree of discomfort; such as stinging, pin-pricking sensation, heat or tightness when receiving a chemical peel.

_____ I understand there are no guarantees as to the results of this treatment, due to many variables, such as: age, condition of skin, sun damage, smoking, climate, etc

_____ I understand I may or may not actually peel, that each case is individual. The amount of peeling does not correlate with the degree of improvement.

_____ I understand that in higher grade peels there may be slight blistering and/or scabbing.

_____ I understand this treatment is a cosmetic treatment and no medical claims are expressed or implied.

_____ I understand to achieve maximum results, I may need several treatments.

_____ I understand that although complications are very rare, sometimes they may occur and prompt treatment is necessary.

_____ I understand in the event of any complications, I will immediately contact the practitioner who performed the treatment and my physician to get medical treatment.
_____ I agree to refrain from tanning in tanning booths or outdoors while I am undergoing treatment, and the 30 days following the end of the treatment series.
_____ I understand extended direct sun exposure is prohibited while I am undergoing treatment, and the daily use of sunscreen protection with a minimum of SPF 30 is mandatory.
_____ I agree that SPF in makeup is not adequate sunscreen protection and will use a separate sunscreen with a minimum of SPF 30 while undergoing treatment.
_____ I have not had any other chemical peel of any kind within 30 days of this treatment, whether it is performed at this location or any other location.

I hereby agree to all of the above statements and agree to having a chemical peel treatment performed on me. I further agree to follow all post-peel care instructions as I am directed.

Guardian Signature (if under 18): _____

Print Name: _____ Date: _____

Client Signature: _____

Print Name: _____ Date: _____

Practitioner Signature: _____

Print Name: _____ Date: _____

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Photograph and Publicity Release Form

I, _____, give my permission to use my likeness, image, and/or appearance as such may be embodied in any pictures, photos, video recordings, digital images, and the like, taken or made on behalf of Laura McElroy Beauty, LLC. I agree that Laura McElroy Beauty, LLC has complete ownership of such pictures, etc., including the entire copyright, and may use them for any purpose consistent with the Laura McElroy Beauty, LLC mission. These uses include, but are not limited to illustrations, bulletins, exhibitions, videotapes, reprints, reproductions, publications, advertisements, and any promotional or educational materials in any medium now known or later developed, including the Internet. I acknowledge that I will not receive any compensation, etc. for the use of such pictures, etc., and hereby release Laura McElroy Beauty, LLC and its agents and assigns from any and all claims which arise out of or are in any way connected with such use.

***All photos will be obscure and respectful, showing minimal parts of the treated areas unless otherwise agreed to by the client.

I have read and understood this consent and release.

I give my consent to and authorize Laura McElroy of Laura McElroy Beauty, LLC to use my likeness to promote the company, and/or their activities.

Guardian Signature (if under 18): _____

Print Name: _____ Date: _____

Client Signature: _____

Print Name: _____ Date: _____

Practitioner Signature: _____

Print Name: _____ Date: _____

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Cancellation, Payment, & Refund Policy

Laura McElroy of Laura McElroy Beauty, LLC strives to give excellent skincare and revision services to help her clients feel amazing and regain confidence. Appointments are lengthy in time and multiple hours are blocked for each client.

In an attempt to be consistent in our policies, we have a Client Appointment Cancellation, Payment, & Refund Policy.

APPOINTMENTS:

When an appointment is made, that time is set aside for you. When that time is missed, it cannot be used to treat another client in need of services.

APPOINTMENT POLICY:

Requires a 48 Hour Cancellation Notice in the event you need to reschedule your appointment. This allows for another client to move into that time slot. If you miss your appointment and do not call, email, or text 48 hours prior to your appointment time, it will be considered a missed appointment unless it is an emergency.

A fee of $35 will be charged to your card on file for a missed Consultation and a $100 fee will be charged to your card on file for a missed Skin Rejuvenation Facial Treatment, Scar Revision/Relaxation Treatment, Stretch Mark Treatment, or Restorative Cosmetic Tattooing Appointment. If a client accumulates 3 missed appointments, they will have to start the series from the beginning with fewer guarantees of maximum results for time loss in between appointments.

Additionally, if the client is late for their appointment, the service will be performed according to the time remaining.

PAYMENTS AND DEPOSITS:

All payments are due on time according to the TREATMENT PLAN agreed upon. A credit card will remain on file at the start of the series for processing. If a client misses or has to reschedule their appointment and there is a payment due that day, the card on file will be charged the amount agreed to per the TREATMENT PLAN. A $500-$2000 Deposit is required for new clients to hold their initial appointment.

REFUNDS:

Laura McElroy Beauty, LLC has a NO REFUND POLICY for services rendered, future services paid for, series paid for in advance, or products. Laura McElroy Beauty, LLC will give studio credit for services we offer within a 6 month period. Credit can be transferred if agreed to by Laura McElroy Beauty, LLC.

We thank you for your patronage and understanding!

Client Signature: _____

Print Name: _____ Date: _____

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AFTERCARE INSTRUCTIONS

SKINCARE:

FOLLOW THE SCAR FOOD PRODUCT AFTERCARE INSTRUCTIONS YOU ARE GIVEN POST PROCEDURE. ALWAYS USE Q-TIPS OR APPLICATOR TO APPLY PRODUCTS OR FRESHLY WASHED HANDS AFTER PROCEDURE TO ELIMINATE BACTERIA TO THE AREAS TREATED. DO NOT TOUCH AREAS WITH DIRTY HANDS, SCRATCH OR RUB. KEEPING THE AREA MOIST AT ALL TIMES WILL RESULT IN A RAPID HEALING.

DURING HEALING:

DAY 1-3: COLD COMPRESSION IS RECOMMENDED.

DAY 1-7: PROHIBIT USE OF AHA'S, BHA'S, RETINOL, RETIN-A, HQ OR PRODUCTS CONTAINING ALCOHOL AS THIS MIGHT IRRITATE, CAUSE ADDITIONAL REDNESS AND POTENTIALLY BURN RESULTING IN HYPERPIGMENTATION. PATIENTS WHO HAVE CAMOUFLAGING PERFORMED SHOULD REFRAIN FROM USING ALL OF THE ABOVE INDEFINITELY TO PREVENT FADING OF THE FLESH TONE PIGMENTS.

EXPOSURE:

DO NOT EXPOSE THE AREA(S) TO SUN, HEAT, TANNING BEDS, SAUNAS, JACUZZIS, STEAM ROOMS, HOT YOGA, HOT WATER OR EXCESSIVE WORKOUTS THIS COULD CAUSE YOUR BODY TEMPERATURE TO INCREASE AND POTENTIALLY HYPERPIGMENT THE NEW TISSUE FORMING.

CLEAN AND CARE:

WASH GENTLY AND FOLLOW WITH HOMECARE PRODUCTS ACCORDINGLY. BE CAREFUL NOT TO TAKE SUPER HOT SHOWERS, PULL OR LIFT SCABS. GENTLY APPLY MOISTURIZERS AND SPF 30 OR MORE OVER THE TREATED AREAS AS NEEDED. KEEP AREA MOIST THROUGHOUT THE DAY. USING SPF 30 OR MORE DAILY IS MANDATORY IN ORDER TO PROTECT THE NEW TISSUE FROM THE SUN.

HEALING CYCLE:

DAY 1-3: SLIGHT INFLAMMATION & REDNESS WILL APPEAR AROUND THE TREATMENT AREAS. THIS IS NORMAL. ICE PACKS CAN BE USED TO REDUCE INFLAMMATION OR SWELLING. FOR PROCEDURES ON LOWER BODY PLEASE REFRAIN FROM TIGHT CLOTHING UNTIL AREAS HAVE COMPLETELY HEALED.

DAY 4-7: SLIGHT SCABBING MAY APPEAR AND WILL SHED DURING FACIAL AND BODY WASHINGS. DO NOT PULL OR PICK AT SCABS. IF A SCAB IS HANGING ON BY A THREAD APPLY A LIBERAL AMOUNT OF SCAR BUTTER OR VASELINE AND MASSAGE GENTLY OVER SCAB FOR IT TO RELEASE. THIS WILL PREVENT IN HARMING THE TISSUE OR PULLING OUT PIGMENT.

DAY 7-14: THE TREATED AREA COULD BE RED OR PINKISH IN COLOR AND SLOUGHING OF DEAD SKIN MAY BE CONTINUE... THIS IS A NORMAL. REMEMBER NO SUN, HEAT OR HOT WATER TO AREAS TREATED AS THEY WILL HYPERPIGMENT. CONTINUE TO PROTECT YOUR SKIN WITH SPF 30 OR MORE. WEAR HATS TO DOUBLE PROTECT THE FACE.

MASSAGE:

IF RECOMMENDED POST PROCEDURE, GENTLY MASSAGE THE TREATMENT AREA. THIS WILL HELP SCAR TISSUE FRAGMENTS UNDERNEATH THE EPIDERMIS TO SOFTEN AND CONTINUE TO RELAX.

MAKEUP:

YOU MAY APPLY A LIGHT LAYER OF MINERAL MAKEUP TO THE TREATED AREAS. IT IS HIGHLY RECOMMENDED TO WAIT AT LEAST 1 DAY TO APPLY. CONCEALER IS NOT RECOMMENDED AS THIS WILL ENHANCE THE AREAS AND CAKE UP ON TOP OF WOUNDS MAKING IT HARDER TO CLEAN.

SPRAY TANNING:

AVOID SPRAY TANNING UNTIL AREA HAS HEALED COMPLETELY, THEREAFTER USE A THICK BARRIER CREAM OR SHEA BUTTER TO PREVENT SCAR(S) FROM ABSORBING DYES BEFORE GETTING SPRAYED. IF SCARS ABSORB YOUR THESE DYES THEY WILL BECOME DARKER IN APPEARANCE AND CAUSE SETBACKS IN THE PROCESS.

FOLLOW UP:

MAKE ALL OF YOUR SCHEDULED APPOINTMENTS AND CONTACT ME IMMEDIATELY SHOULD YOU HAVE ANY QUESTIONS OR CONCERNS.

Guardian Signature (if under 18): _____

Print Name: _____ Date: _____

Client Signature: _____

Print Name: _____ Date: _____

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SCARS | SKINCARE REGIMEN | STRETCH MARKS

AM	PM
Cleanse	Cleanse
Compress *	Compress *
Scar Light (Step 2)	Scar Infuser **
Scar Correct	Scar Light (Step 2)
Scar Cells	Scar Correct
Scar Soothe	Scar Cells
Scar Butter	Scar Soothe
	Scar Butter

*Use the Compress 3-5 times a day immediately after post-op for 5-7 days or as needed after treatments for 1-3 days. Apply over a cloth barrier… do not apply directly on skin.

**Use the Scar Infuser once a week. (Roll in small sections over the scar, vertically and horizontally, 4 times each.)