Sierra Nevada Wellness Center

3160 Vista Blvd. Sparks, NV 89436

(775) 352-7200

VIORA REACTION TREATMENT

Please, read carefully and ***initial*** next to each statement:

_____I am not pregnant, nursing, or trying to become pregnant.

_____I have not received electrolysis, tweezed, waxed, threaded, laser hair removal or removed hair from the follicle any method other than shaving in the past 3-4 weeks.

_____For best results, I have been informed multiple treatments will be necessary.

_____For best results, I understand Viora reaction treatments need to be scheduled consecutively and it is recommended they are scheduled 2-4 weeks apart depending on the area being treated.

_____I understand any redness, swelling, and/or discomfort usually resolves within several hours, but may last for 2-3 days.

_____The treated area may feel like a sunburn or windburn (minor discomfort) for a few hours after treatment.

_____I am aware I will be given aftercare instructions regarding care of the treated area(s). I understand it is important to follow all aftercare instructions carefully to minimize the risks of incomplete healing, scarring, and/or skin textural changes.

_____I understand I need to protect my skin from the sun and I need to use a broad spectrum UVA/UVB protective sunscreen in order to reduce the risk of damage to the skin. I understand I must wear a broad spectrum UVA/UVB protective sunscreen during instances where I am exposed to sunlight. These instances include, but are not limited to: sitting in the car, walking to the mailbox or sitting in sun light of any kind.

_____I understand Viora reaction treatment is a cosmetic procedure that is elective and is not covered by insurance.

_____I understand, recognize, and acknowledge Sierra Nevada Wellness Center, the laser technicians, estheticians and/or any other staff members of Sierra Nevada Wellness Center have made no guarantees to me concerning the results of my laser treatments.

_____I have provided my past and current medical history and medications.

_____Contraindications of this procedure have been discussed in detail with me.

_____I have read and understand all information presented to me concerning this procedure before signing this consent form.

_____Questions I have about the risks, benefits, and results pertaining to this procedure have been answered and discussed to my satisfaction.

Patient Name (printed): _____ Date:_____

Patient Signature: _____ Date: _____

Staff/Witness Signature: _____ Date: _____