Plasma Fibroblast

Plasma Fibroblast is a beauty enhancement procedure performed by licensed medical aesthetician and certified technician; Andrea Rozanek, who uses an FDA cleared device called Plamere Plasma Pen to shrink the skin using a sterile, disposable probe.

Fibroblasts are the collagen producing cells in the skin. Fibroblast treatment is performed with a device called Plamere Plasma Pen, which is used to produce plasma waves. The waves are directed as tiny light spots along the wrinkle lines. The tip of the pen never touches the skin. The pen is held above the skin and a tiny plasma arc connects the tip of the device to the surface of the dermis. Using plasma waves, the old collagen is removed by sublimation (evaporation), and fibroblasts are stimulated to produce new collagen. The targeted skin contracts and is essentially eliminated without any cutting, which results in the tightening and shrinking of the targeted skin.

This advanced procedure helps to revive natural levels of the Collagen, Hyaluronic Acid and Fibronectin needed for fresh youthful skin. A series of tiny brown spots are strategically placed to attain the desired result. The skin around the dot tightens instantly, pulling the cells closer together.

No over tightening will occur. *The evaporated old collagen is seen as tiny brown scabs on the treated area. The tiny "microdot", brown scab or protective crust, or carbon crust on the surface will fall off on their own in approx. 5-10 days.*

It is very Safe, low-risk, and highly effective. *As with most cosmetic treatments, a consultation with an experienced, trained practitioner prior to service, as well as a strict aftercare routine, is required to promote proper healing and to help you achieve the maximum results. Results can be seen in 6 to 8 weeks.*

Name: ____

Phone Number: ____

Email: ____

Date of Birthday: ______________________________________

Date: ____

Plasma Fibroblast Consent

When initialing and signing, you are stating that *you understand and accept* the terms of this treatment.

- *You have chosen a cosmetic procedure that is not medically necessary.* Initials:______
- *Plasma Fibroblast is an art process-not an exact science- and can not guarantee an exact shrinkage result due to individual skin elasticity and healing process.* Initials:______
- *You may be required to return for additional treatments before your overall procedure is deemed complete. The payment and time frames for any additional work will be discussed and agreed upon prior to the treatment commencing. Dependent on the area of treatment, additional treatments can not be performed sooner than 4 weeks or later than 8 weeks after the initial and subsequent visits. It is imperative for the area to fully heal prior to additional treatments.* Initials:______
- *A treatment plan record will be kept by Andrea Rozanek to record area's you have chosen, anesthetic used as well as pre and post treatment photos.* Initials:______
- *The skin type of each guest is different, and the healing process may lead to mild discoloration of the skin.* Initials:______
- *After each treatment, swelling and redness may occur. Some guests may experience extreme swelling. You will be given advice on how to reduce and minimize the risk.* Initials:______
- *The treatment includes a small burn to the skin, you may experience a smell of charring. This is completely normal.* Initials:______
- *You must adhere strictly to NO SUN EXPOSURE to the treated area following your treatment for 3 to 4 weeks. This is extremely important and will greatly reduce the risk of hyperpigmentation.* Initials:______
- *The treated area must heal properly. Picking, plucking, scrubbing or manipulating the treatment area could make the treatment area appear uneven, discolored or scarred, requiring further treatments.* Initials:______
- *Beware that cosmetic or medical skin altering procedures such as plastic surgery, implants, injectables and weight loss or gain may alter the Plasma Skin Tightening treatment look.* Initials:______

Photographic Consent: *I consent to photographs being taken before, during and after each procedure. I agree to these photos will be used only with my written consent for promotional purposes.*

Name: ____

Signature: ____

Date: ____

Plasma Fibroblast Consent

1. **Do you feel fit and well enough to have the procedure? ………………………... Yes ___ NO ___**
2. **Do you have any allergies or experienced allergic reactions to medicine, latex, numbing solution, plaster etc.? ……………………………………………………………………………… Yes ___ NO ___**
   If yes, explain:
   ___
3. **Are you currently taking medications?.. Yes ___ NO ___**
   If yes, list:
   ___
4. **Do you plan on having microneedling, laser or a peel to the treated area in 1-3 months? ……………………………………………………………………………… Yes ___ NO ___**
5. **Do you suffer from epilepsy or seizures? ……………………………………….. Yes ___ NO ___**
6. **Do you have any known infectious disease? .... Yes ___ NO ___**
7. **Do you suffer from high or low blood pressure? ……………………………….. Yes ___ NO ___**
8. **Do you have diabetes? ……………………………………………………………… Yes ___ NO ___**
9. **Do you have respiratory problems? ……………………………………………….. Yes ___ NO ___**
10. **Do you have problems with bleeding, scarring or healing? ……………………... Yes ___ NO ___**
11. **Do you or could you possibly have HIV or AIDS? ………………………………. Yes ___ NO ___**
12. **Do you suffer from heart problems? ……………………………………………… Yes ___ NO ___**
13. **Do you suffer from Hepatitis? ……………………………………………………… Yes ___ NO ___**
14. **Do you have lymphatic issues? …………………………………………………….. Yes ___ NO ___**
15. **Do you suffer from Hemophilia? ………………………………………………….. Yes ___ NO ___**
16. **Do you have skin problems? (i.e. Eczema, Psoriasis) …………………………...... Yes ___ NO ___**
    If yes, explain:
    ___
17. **Do you suffer from Keloid scarring? ……………………………………………… Yes ___ NO ___**

I understand that Andrea Rozanek will be in direct contact with me in relation to my plasma skin tightening treatment. All other equipment is sterilized before use, all surfaces involved in the process are clean and protected and the treatment involves use of a disposable probe.

I understand the importance of my accurate and complete medical history, desired treatment area's and anticipated subsequent treatments and results. I understand withholding any medical information and expectations may be detrimental to my health and safety during and after the treatment. I understand that if there is any change in my medical history it is my sole responsibility to inform Andrea Rozanek.

I hereby consent to receiving a plasma skin tightening treatment. Andrea Rozanek has explained the terms and conditions of the treatment and I have fully understood these. I hereby give written consent to Andrea Rozanek, who has been fully trained, to carry out the treatment of my choice as requested by me on this consent form.

Name: ____

Signature: ____

Date: ____

POINTILLISM LIFT

Plasma Fibroblast - Patient Intake Form

Date: ______________________________

Name: ____ Date of Birth: _______/_______/_______

Address:____

____

Cell #:(________)_______________________ Email:____

How did you hear about Plasma Fibroblast?____

If internet, which site: Google ____ Website ____ Instagram ____ Facebook ____ Other ____

Would you like to be contacted about future promotions? Yes ___ No ___

What areas on your face and/or body would you like to consult about today? _______________________

____

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1) Do you have any special skin problems or concerns pertaining to your face or body? Yes ___ NO ___

   If Yes, please specify ____

2) Do you use Retin-A, AHA or Retinol products? Yes ___ No ___

   If Yes, in the last 2 weeks? Yes ___ No ___

3) Have you had chemical peels, laser or microdermabrasion recently? Yes ___ No ___

   If Yes, in the last 2 weeks? Yes ___ No ___

4) Are you currently taking acne medication? Yes ____ No____

   If Yes, Specify ______________________

5) Have you had Botox or Filler in the last 1-3 months? Yes ___ No ___ If Yes, When ________________

6) What skin care products are you currently using (Face)?

   Face Cleanser ____________________________ Day Moisturizer ______________________________

   Eye Cream_______________________________ Night Moisturizer_____________________________

   SPF ____________________________________ Exfoliator/Scrub_______________________________

   Other ____

7) Do you suffer from Keloid Scarring? Yes ___ No ___

HEALTH INFORMATON

Do you have any chronic medical problems? (Check all that apply):

High/Low Blood Pressure..___
Heart Problems ..…………___
Heart Failure……………..___
Seizures …………………..___
Diabetes …………………. ___

Kidney Disease …………___
Psychiatric Diagnosis……___
Hemophilia Blood Issues. ___
Liver Disease …………… ___
Cancer ……………………___

HIV or AIDS …………..___
Stroke…………………..___
Hepatitis………………___
Other ____________________
____

If Female, could you be pregnant? Yes ___ No ___

Please list **ALL medications** and/or dietary supplements including:

____

____

____

____

Please list **ALL allergies** and describe reactions: (i.e. Shellfish, Latex, Numbing Solution, etc.)

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ASSIGNMENT AND RELEASE:

I understand that I am financially responsible for all charges related to my future treatments.

Print Name: ___________________________________

Signature: ____________________________________

Date: ____