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AOB Med Spa
LATISSE® CONSENT FORM

_____

Last Name **First Name**

_____

DOB **Referred by:**

_____

Email Address: **Street Address, State and Zip:**

This consent form is designed to verify that you have been satisfactorily informed and educated in respect to your skin care treatment, so that you may make an educated decision as to whether to purchase this treatment. Please read and initial each paragraph below, and freely ask us any questions you may have.

GENERAL INFORMATION:

_____ I understand that I am requesting a prescription for Latisse® which is approved by the FDA to treat hypotrichosis (inadequate or not enough eyelashes) of the eyelashes by increasing their growth including length, thickness, and darkness. In published studies, nearly 80% of subjects responded to treatment after 16 weeks.

_____ Prior to starting this treatment, I have been candid in revealing any condition that may have a bearing on this treatment, such as pregnancy, breastfeeding, history of glaucoma, ocular hypertension, macular edema, aphakia (absence of the lens of the eye), intraocular inflammation (e.g., uveitis), or hypersensitivity to Latisse® (or bimatoprost) or any other ingredient in this product.

_____ I understand that Latisse® may be absorbed by soft contact lenses. Contact lenses should be removed prior to application of solution and may be reinserted 15 minutes following its use.

RISKS/SIDE EFFECTS:

_____ I understand there is a risk of eye itching, eye redness, darkening of the skin, eye irritation, dryness of the eyes, redness of the eyelids, and allergic reaction.

_____ I understand that in clinical trials, Latisse® lowered intraocular pressure, however the magnitude of the reduction was not cause for clinical concern.

_____ I understand that increased iris pigmentation has occurred when bimatoprost solution was administered and that increased brown iris pigmentation is likely to be permanent should it occur. Iris color changes may not be noticeable for several months to years.

_____ I understand that bimatoprost has been reported to cause darkening of the eyelid. This side effect has been reported to be reversible upon discontinuation of treatment.

_____ I understand that there is the potential for hair growth to occur in areas where Latisse® comes in repeated contact with the skin surface. It is important to apply Latisse® only to the skin of the upper eyelid margin at the base of the eyelashes and to blot any excess Latisse® to avoid it running onto the cheek or other skin areas.

_____ I understand that Latisse® should be used with caution in individuals with active intraocular inflammation

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because the inflammation may be exacerbated.

_____ I understand that macular edema (swelling of the small area of the retina responsible for central vision) has been reported during treatment with bimatoprost solution for elevated intraocular pressure.

_____ I understand that Latisse® must be used exactly as directed to reduce the risk of complications and side effects and that any misuse of Latisse® could increase the chances of unintended side effects.

USE:

1. The Latisse® bottle must be kept intact during use.
2. Place one drop on the single use per eye applicator.
3. Bottle tip should never be allowed to contact any other surface to avoid contamination.
4. Sterile applicators may only be used on one eye and then discarded. Reuse of applicators increases the potential for contamination and infections.
5. Do not apply Latisse® to bottom lashes.
6. Do not use Latisse® more than once per day. Additional application will not increase results but will increase the risk of possible complication and side effects.
7. Upon discontinuation of Latisse®, eyelash growth is expected to return to its pre-use level.
8. Do not use Latisse® on any other areas of the body. Studies have not been performed as to the safety and effective ness in any area other than the eyelashes.

AUTHORIZATION AND WAIVER

_____ I fully understand that this product has limited applications. I am aware that the practice of medicine and aesthetics are not exact sciences, and I acknowledge that my provider cannot guarantee quality and/or results or freedom from complications. I acknowledge that I have had the opportunity to ask questions, and that I fully understand the treatment.

_____ I understand and acknowledge that there are risks involved with the skin care treatment, including but not limited to those side effects listed above. I have had the opportunity to ask questions regarding these risks and other possible complications. I understand that any false or misleading information I have given may lead to undesired results and complications and hereby release and hold harmless AOB Med Spa from any and all liability if such results or complications occur. I further understand that my failure to follow use instructions may also lead to undesired results, complications or effects and hereby release and hold harmless AOB Med Spa from liability if such results or complications occur.

_____Any payment made on AOB Med Spa treatments is non-refundable. Any unused treatments will be available as an in-house credit on your account, and can be used to purchase treatments or products.

I certify that I have read and fully understand the above paragraphs, that I have had sufficient opportunity for discussion and to ask questions, and that I hereby consent to the procedure described above.

_____ _____ Client Signature
(or Responsible Guardian) Date

_____ _____
Witness Date

_____ _____
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