



Jax Medi Spa Informed Consent for Treatments

Florida Medical Consent Acknowledgment

This informed consent is provided in accordance with Florida Statute §766.103 (Florida Medical Consent Law). By signing this document, you acknowledge that the nature, purpose, benefits, risks, and alternatives of the procedures performed at Jax Medi Spa have been explained to you, and you have had the opportunity to ask questions and receive satisfactory answers. You understand that no guarantees have been made regarding the results, and that expected side effects and complications have been disclosed to you.

AESTHETICS

Services: Brows and lashes (wax/tint/lamination/lift), facials, microneedling (cosmetic), teeth whitening, waxing. These are non-invasive aesthetic services designed to improve skin health, appearance, and cosmetic features through topical treatments, exfoliation, or hair removal.

Potential Risks & Expected Effects:

- Temporary redness, irritation, or sensitivity
- Breakouts, dryness, or peeling (especially after exfoliating facials or peels)
- Allergic reaction to skincare ingredients, wax, or tinting products
- Mild discomfort during waxing or microneedling procedures
- Temporary sensitivity after teeth whitening

Consent:

I acknowledge that the nature, purpose, risks, and expected results of aesthetic treatments have been explained to me, including alternatives and the option of no treatment. I understand these are elective, non-medical services. I accept the known risks and complications, including those listed above, and voluntarily consent to treatment. This informed consent is provided in accordance with Florida Statute §766.103. PATIENT INITIAL: _____

ANTI-AGING AND LONGEVITY

Services: Chemical peels, microneedling (medical depth), microdermabrasion, red light therapy, high frequency, hormonal balancing, IV therapy, pharmacotherapeutics including biopeptides, stem cell therapies. These services aim to rejuvenate skin, support hormonal health, and promote wellness using medical-grade products, devices, and IV infusions. Some procedures involve penetration of the skin or administration of substances by a licensed medical professional.

Potential Risks & Expected Effects:

- Temporary redness, swelling, peeling, or sensitivity (microneedling, peels)
- Hyperpigmentation, hypopigmentation, or scarring if post-care is not followed
- Bruising, tenderness, or infection at IV sites
- Allergic reactions to infusion components or topical ingredients
- Rare but serious complications: vascular occlusion, infection, nerve injury, migration of product, tissue necrosis, or embolism



- Vitamin injections may cause local irritation or systemic reactions if allergic

Consent:

I acknowledge that I have been informed of the risks, benefits, and alternatives to injectable treatments. I understand that injectables must be administered by a licensed medical professional. I accept the known risks and voluntarily consent to these procedures, understanding that results vary. This consent complies with Florida Statute §766.103. PATIENT INITIAL: _____

HAIR TREATMENTS

Services: Hair microneedling with Exosome, PRP, or DeRive. These treatments involve microneedling or injections to stimulate hair growth and scalp health.

Potential Risks & Expected Effects:

- Temporary pinpoint bleeding, redness, swelling, or sensitivity
- Scalp tenderness or bruising at injection sites
- Temporary shedding before regrowth cycle begins
- Infection, scarring, or pigmentation changes if post-care is not followed
- Rare inflammatory response to biologics (PRP, Exosomes)

Consent:

I acknowledge that the procedure, risks, and alternatives have been explained to me, including no treatment. I accept the disclosed risks and voluntarily consent to hair restoration treatments. This informed consent complies with Florida Statute §766.103. PATIENT INITIAL: _____

LASER TREATMENTS

Services: IPL, laser hair removal, laser skin rejuvenation, laser tattoo removal, laser vein (spider) treatments. Laser treatments use focused light energy for hair reduction, skin rejuvenation, pigment targeting, or vascular treatments.

Potential Risks & Expected Effects:

- Temporary redness, swelling, or warmth at the treated site
- Pigment changes (hyperpigmentation or hypopigmentation)
- Blistering, scabbing, or mild burns
- Re-activation of herpes simplex virus (e.g., lip area)
- Scarring or delayed healing if aftercare is not followed
- Rare allergic reaction to topical anesthetics or cooling gels

Consent:

I understand the nature, purpose, and risks of laser procedures. I have received pre- and post-care instructions and understand the importance of following them. I accept the known risks and voluntarily consent to treatment. This informed consent is provided pursuant to Florida Statute §766.103. PATIENT INITIAL: _____

Please check one:

☐ YES – I give permission for Jax Medi Spa to use my images for marketing and educational purposes.



☐ NO – I do not give permission for my images to be used for marketing; they may only be used for internal records.

PATIENT INITIAL: _____

HIPAA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have received and reviewed a copy of Jax Medi Spa's Notice of Privacy Practices, which explains how my medical information may be used and disclosed under Florida Statute §456.057 and federal HIPAA regulations (45 CFR 164.520).

Patient Name (Printed): _____ Date: _____

Patient Signature: _____

FINAL ACKNOWLEDGMENT

I understand that these procedures are elective and not medically necessary. I acknowledge that no guarantees have been made as to results. I accept the known and disclosed risks associated with the procedures selected and assume full responsibility for expected complications or side effects.

This consent does not waive any rights under Florida law, nor does it release Jax Medi Spa or its staff from liability for negligence. It does, however, acknowledge that I have been informed of the risks as required under Florida Statute §766.103 and that I freely consent to treatment.

Patient Name (Printed): _____ Date: _____

Patient Signature: _____

Provider Name & Title (Printed): _____

Provider Signature: _____ Date: _____