



LASER PACsm Cosmetic Laser/IPL, and LED Insurance Program

Please fax or mail the attached application for a free no obligation price quotation

191 Maplewood Avenue, Maplewood New Jersey 07040
fax: 973-763-1635
toll free: 800-763-4775
internet: www.marineagency.com
California License # 0645476

TRAINING REQUIREMENTS

Level 1 – Basic (LED) Services – Photorejuvenation and wrinkle reduction services. Treatment of rosacea, veins, and age/sun spots with a Light Emitting Diode (LED) device using under 20 j/cm² at 10mm or greater spot size.

TRAINING REQUIRED: One year experience and/or specific training for each machine and treatment.

Level 2 – Laser/IPL Hair Removal Services – Hair removal/reduction with a laser or IPL device.

TRAINING REQUIRED: One year experience and/or 30 hours specific training for each machine and treatment.

Level 3 – Laser/IPL Professional Services – Includes all of the above, without fluency or spot size restriction.

TRAINING REQUIRED: One year experience and/or 30 hours specific training for each machine and treatment.

Level 4 – Laser/IPL Professional Services with Laser Tattoo Removal – Includes all of the above, without fluency or spot size restriction. A \$5,000 deductible will apply for this level.

TRAINING REQUIRED: One year experience and/or 30 hours specific training for each machine and treatment.

Training requirements above apply to services performed on Fitzpatrick Skin Types I – IV. Coverage for services performed on Fitzpatrick Skin Types V – VI requires a minimum of one year experience. A \$5,000 deductible applies to coverage for services performed on Fitzpatrick Skin Types V – VI.

2.5 What specific light source equipment have you been trained in ? _____

2.6 What services do you offer:

- Laser Hair Removal Photorejuvenation Tattoo removal
 - Veins (up to 1.5mm, spider veins) Rosacea Age/sun spots Nonablative wrinkle reduction
- If you checked Veins, please state the body areas (i.e.; facial, leg, etc.) and maximum vein diameter (mm):

2.7 What types of services, not listed above, do you offer? _____

2.8 Education in light source equipment: List all information as requested and include certificates of completion

Date	Class Title	Number of Hours
------	-------------	-----------------

_____	_____	_____
_____	_____	_____
_____	_____	_____

2.9 Do you want coverage for Fitzpatrick Skin Types V & VI? (1 year experience & \$5,000 deductible required)

- Yes No

3.0 Specific light devices you want to be insured for (no coverage will be provided unless listed)

Laser/IPL Type/Light devices	FDA Class	Maximum Fluence (j/cm ²)	Maximum Spot Size (mm)
------------------------------	-----------	--------------------------------------	------------------------

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

WARRANTIES

★ I understand:

- The Fitzpatrick Scale. I will not be insured to work on Skin Types V & VI unless specifically endorsed.
- It is warranted that for Class III & IV devices goggles must be worn by all people in the room at all times the laser is in use. All reflective services will be covered
- Every client must sign a consent & medical history form. No coverage will apply if there is not a signed form on file.
- For Class IV laser use, the room door will stay locked at all times the laser is in use or a sign must be posted on door: LASER IN USE, DO NOT ENTER
- I understand that there is no coverage for prescription anesthetic use.
- I understand that there is no coverage for work in the eye area other than the brow and glabella.
- No insurance will be offered for any equipment that is not listed on the policy.
- No insurance will be offered for the following treatments: i. any raised tissue with its own blood supply (such as moles), ii. skin that is ulcerated, broken (not intact), blistered or has open sores; iii. bulging veins or veins over 1.5 millimeters

HISTORY

4.1 Do you currently have insurance coverage? Yes No

If claims made, indicate most recent retroactive date: _____

If yes, please indicate the following:

Insurer	Policy #	Liability Limits	Premium	Expiration Date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

4.2 List all claims history whether or not insured: If none, state "none".

Year of Claim	Nature of Injuries	Equipment Involved	Details, if pending	Amount, if settled
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

4.3 Do you have knowledge of an event, circumstance or occurrence (other than listed in 4.2 above) prior to the effective date of the proposed policy, or do you foresee that a claim may be brought as a result of said event, circumstance or occurrence? Yes No

If yes, describe details of the event: _____

I understand and agree this Application and any supplements attached hereto will be relied upon for issuance of any policy. I further understand and agree that failure to provide a true and accurate response to the foregoing questions may, at the option of the company, result in the voiding of the insurance issued in reliance on this application and/or denial of claims under any policy issued.

I authorize and consent to investigations of information bearing upon moral character, professional reputation and fitness to engage in the activities of my business including authorization to every person or entity, public or private, to release to all Lloyds of London syndicates, any documents, records or other information bearing upon the foregoing. I understand and agree these investigations shall not be confined to information submitted in this application, but shall include any other sources of information deemed relevant by the Company as may be authorized by law.

Furthermore, I understand that the policy applied for will apply only to CLAIMS FIRST MADE AND REPORTED to the Company in writing within the period of coverage shown on the certificate of insurance issued with the policy or certificate on the date the policy is cancelled or terminated, whichever comes first or as otherwise provided by the policy.

I understand this insurance is being provided through a surplus lines company and the insurer may not be subject to all the insurance laws and rules in my state and the risk is not protected by the State Insurance Insolvency Fund.

THIS APPLICATION MUST BE SIGNED BY THE APPLICANT WITHIN 30 DAYS OF BINDING. SIGNING THIS FORM DOES NOT BIND THE COMPANY TO COMPLETE THE INSURANCE. COVERAGE BECOMES EFFECTIVE WHEN ACCEPTED BY THE COMPANY.

APPLICANT	TITLE	
TODAY'S DATE	REQUESTED EFFECTIVE DATE	1,000,000 OCC / 2,000,000 AGG LIABILITY LIMIT REQUESTED

One box below must be checked:
 I ELECT TO PURCHASE TERRORISM COVERAGE AT A 10% ADDITIONAL PREMIUM
 I DO NOT ELECT TO PURCHASE TERRORISM COVERAGE AT A 10% ADDITIONAL PREMIUM

LANDLORD AS ADDITIONAL INSURED: _____
ADDRESS: _____



LASER PACsm Cosmetic Laser/IPL, and LED Insurance Program

FORMS CONFIRMATION PAGE

Option A – Lloyd’s of London approved forms

You have the option of using the enclosed Lloyd’s of London approved informed consent, medical history, and aftercare instruction forms.

To use these forms, indicate your preference, sign & date below, and return with your application materials.

Option B – Use your own forms

If using your own forms, please return copies of your informed consent, medical history, and aftercare instruction forms for ALL laser, laser-type, and light-based treatments. The insurance company has specific minimum requirements for each type of form as follows:

Informed consent(s)

- A. Must state that hyper- or hypo-pigmentation is possible
- B. Must state that hyper- and/or hypo-pigmentation could take 3-6 months to heal
- C. Must release laser center, medical staff, and specific technician from liability associated with the service. (example “I release the technician, laser center, and all staff from liability associated with these procedures.”)
- D. Must state that compliance with recommended aftercare guidelines are crucial for healing, prevention of scarring, and hyperpigmentation.

Medical history form that your clients sign

- A. Must include the specific question “Are you currently on any mood altering or depression medication?”
- B. Must be a detailed medical history and should be signed by your customer.

Aftercare / Post Treatment Instructions

- A. Must suggest the use of sunscreen with minimum SPF25 for at least one to two months following treatments.
- B. Must make additional aftercare instructions relevant to the services rendered.

- Select one:**
- I am accepting **Option A** above. I will use the Lloyd’s of London approved forms. I agree to promptly notify the underwriters of any changes I make to these forms now or in the future.

 - I am accepting **Option B** above. I am enclosing copies of my informed consent, medical history, and aftercare instruction forms. I agree to promptly notify the underwriters of any changes I make to these forms now or in the future.

Signed: _____ **Dated:** _____

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate laser treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name _____ Today's Date _____

Date of Birth _____ Age _____ Occupation _____

Home Address _____ City _____ State _____ Zip Code _____

Home Phone (____) _____ Work Phone (____) _____

Emergency Contact Name and Phone _____

How were you referred to us? _____

Which of the following best describes your skin type? (Please circle one type number)

- I Always burns, never tans
- II Always burns, sometimes tans
- III Sometimes burns, always tans
- IV Rarely burns, always tans
- V Brown, moderately pigmented skin
- VI Black skin

MEDICAL HISTORY

Are you currently under the care of a physician? Yes No

If yes, for what: _____

Are you currently under the care of a dermatologist? Yes No

If yes, for what: _____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? Yes No

Do you have any of the following medical conditions? (Please check all that apply)

- Cancer Diabetes High blood pressure Herpes Arthritis
- Frequent cold sores HIV/AIDS Keloid scarring Skin disease/Skin lesions
- Seizure disorder Hepatitis Hormone imbalance Thyroid imbalance
- Blood clotting abnormalities Any active infection

Do you have any other health problems or medical conditions? Please list: _____

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced) Food Latex Aspirin Lidocaine Hydrocortisone Hydroquinone or skin bleaching agents
Others:

MEDICATIONS

What oral medications are you presently taking? Birth control pills Hormones

Others (Please list): _____

Are you on any mood altering or anti-depression medication? _____

Have you ever used Accutane? Yes No If yes, when did you last use it? _____

What topical medications or creams are you currently using? RetinA , Others (Please list):

What herbal supplements do you use regularly? _____

HISTORY

Have you ever had laser hair removal? Yes No

Have you used any of the following hair removal methods in the past six weeks?

Shaving Waxing Electrolysis Plucking Tweezing Stringing Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? Yes No

Have you recently used any self-tanning lotions or treatments? Yes No

Do you form thick or raised scars from cuts or burns? Yes No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? Yes No If yes, please describe: _____

For our female clients:

Are you pregnant or trying to become pregnant? Yes No Are you breastfeeding? Yes No

Are you using contraception? Yes No

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature _____ Date: _____

**SKIN REJUVENATION, ROSACEA & VEINS, and
non-ABLATIVE WRINKLE WORK
AFTER CARE FORM**

Post Treatment Instructions:

1. Immediately after the treatments, you should apply an ice pack, as there may be mild swelling. It is normal for the treated area to feel like sunburn for a few hours. You should use a cold compress if needed. Avoid any trauma to the skin for up to 2-5 days, such as bathing with very hot water, strenuous exercise, or massage.
2. Avoid picking or scratching the treated skin to achieve your best results. If any crusting, apply antibiotic cream. Some physicians recommend aloe vera gel or some other after sunburn treatment such as Desitin. Darker pigmented people may have more discomfort than lighter skin people and may require the aloe vera gel or an antibiotic ointment longer. Follow instructions as specified by your laser professional.
3. Makeup may be used after the treatment has quit swelling unless there is epidermal bleeding. It is recommended to use new makeup to reduce the possibility of infection. Keep the area moist. Any moisturizer without alpha-hydroxy acids will work.
4. You may shower after the laser treatments in tepid water. The treated area may be washed gently with a mild soap. Skin should be patted dry and NOT rubbed.
5. You will experience redness and bruising from five to fourteen days at the treatment. Avoid direct sun exposure and tanning beds for 1-2 months and throughout the course of the treatment so as to reduce the chance of dark or light spots. Use sunscreen SPF 25 or higher at all times throughout the treatment when going outside.
6. Avoid tweezing, waxing, bleaching or chemical peels during the course of the treatment. Do not use any irritants such as Retin-A, Benzoyl Peroxide or astringents.
7. If work on the leg has been done, wear compression stockings for 48 hours and then during the day while on feet for up to two weeks.
8. Call your physician's office with any questions or concerns you may have after the treatment.

HAIR REMOVAL AFTER CARE FORM

Post Treatment Instructions:

1. Immediately after the treatments, there should be redness and bumps at the treatment area, which may last up to 2 hours or longer. It is normal for the treated area to feel like sunburn for a few hours. You should use a cold compress if needed. If any crusting, apply antibiotic cream. Some physicians recommend aloe vera gel or some other after sunburn treatment such as Desitin. Darker pigmented people may have more discomfort than lighter skin people and may require the aloe vera gel or an antibiotic ointment longer.
2. Makeup may be used after the treatment, unless there is epidermal blistering. It is recommended to use new makeup to reduce the possibility of infection. Just make sure that you have moisturizer on under your makeup. In fact, moisturizer will help the dead hair exfoliate from the follicle, so use moisturizer frequently and freely on the treated area. Any moisturizer without alpha-hydroxy acids will work.
3. Avoid sun exposure to reduce the chance of dark or light spots for 2 months. Use sunscreen SPF 25 or higher at all times throughout the treatment.
4. Avoid picking or scratching the treated skin. DO NOT USE any other hair removal methods or products on the treated area during the course of your laser treatments, as it will prevent you from achieving your best results.
5. You may shower after the laser treatments, and use soap, deodorant, etc. The treated area may be washed gently with a mild soap. Skin should be patted dry and NOT rubbed. Underarm areas, that have been treated, should be wiped with alcohol for 24 hours. You may apply deodorant after 24 hours.
6. Anywhere from 5-30 days after the treatment, shedding of the hair may occur and this may appear as new hair growth. This is not new hair growth, but dead hair pushing its way out of the follicle. You can help the hair exfoliate by washing or wiping with a washcloth.
7. Hair re-growth occurs at different rates on different areas of the body. New hair growth will not occur for at least three weeks after treatment.
8. Call your physician's office with any questions or concerns you may have after the treatment

Please note: Stubbles, representing dead hair being shed from the hair follicle, will appear within 10-20 days from the treatment date. This is normal and will fall out quickly.

Informed Consent
For Removal/Reduction of Brown/Age Spots,
Rosacea & Spider Veins

Name: _____ Date: _____

I authorize _____, to perform the procedure. The light pulsed system may dramatically reduce darkly pigmented sunspots and spider veins. More than one laser session may be necessary to achieve desired results. However, other treatments, including skin care products, are often needed to blend color, reduce sun damage, and give the best results. The FDA has given the clearance for removal of brown spots, spider veins, and rosacea.

The skin treated will be red and swollen with fine, thin scabs forming. Keep the treated areas covered with Polysporin and Aquaphor until the thin scabs fall off. This process will take anywhere from 1-3 weeks. It could take as long as 3-6 months in some rarer cases. Do not scratch the scabs, as that can cause scarring.

We are unable to treat clients that are on ACCUTANE and PHOTSENSITIZING medications. Clients using ANTICOAGULANTS should be noted.

The following problems may occur with treatment:

- 1 **Scarring:** The light pulsed system can create a bruising and a moderate burn or blister to the skin. For an effective treatment, the power (joules) needs to be just below the blistering point which means skin will be red. However slight, there is a risk of scarring.
- 2 **Hyper-pigmentation** (browning) and **Hypo-pigmentation** (whitening) have been noted after treatment, especially with a darker complexion. This usually resolves within weeks, but it can take as long as 3-6 months in some cases. Permanent color change is a rare risk. If you have a lot of color in your skin, a skin lightening cream will be advised to reduce the melanin in your skin before the treatment. Avoiding sun exposure after the treatment is crucial to reduce the risk of color change.
- 3 **Infection:** Although infection following pulsed light treatment is unusual, bacterial, fungal, and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a laser treatment. This applies to both individuals with a past history of herpes simplex virus infections in the mouth area. Should any type of skin infection occur, additional treatment including antibiotics might be necessary. **If you have a history of herpes simplex virus in the treated area we recommend preventative therapy.**
- 4 **Bleeding:** Pinpoint bleeding is rare but can occur following brown spot and spider vein treatment procedures. Should bleeding occur, additional treatment might be necessary.
- 5 **Skin tissue pathology:** Energy directed at skin lesions may potentially vaporize the lesion. Laboratory examination of the tissue specimen may not be possible. Only clearly benign pigmented lesions can be treated. Check with your doctor for a clearance for the treatment.
- 6 **Allergic reactions:** In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations, have been reported. Systemic reactions (which are more serious) may result from prescription medicines. Allergic reactions may require additional treatment.
- 7 Wear sunscreen of SPF 25 or higher before and after treatment to protect your skin.
- 8 I understand I may need multiple treatments for the desired outcome.

9 I understand that exposure of my eyes to light could harm my vision. I will keep the eye protection on at all times.

10 Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, hyper-pigmentation and hypo-pigmentation.

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

ACKNOWLEDGMENT:

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release _____(individual) and _____(facility) and _____(doctor) from all liabilities associated with the above indicated procedure.

Client/Guardian Signature _____ Date _____

Laser Technician Signature _____ Date _____

Informed Consent for Hair Removal

Customer's name: _____ **Date:** _____

Treatment sites: mono-brow, lip, chin, neck, face, arms, fingers, chest, areola, linea, underarms, back, buttocks, bikini, labia, scrotum, thighs, lower legs, feet, and toes.

Combinations: _____.

Previous hair removal methods _____ (shaving, tweezing, waxing, depilatories, electrolysis, laser)

The purpose of this procedure is to diminish or remove unwanted hair. The procedure requires more than one treatment and may produce permanent hair removal. The total number of treatments will vary between individuals. On occasion there are patients that do not respond to treatments. The treated hair should exfoliate or push out in approximately 2-3 weeks.

Alternative methods are waxing, shaving, electrolysis, and chemical epilation.

The following problems may occur with the hair removal system.

- 1 However slight, **there is a risk of scarring.**
- 2 **Short term effects may include reddening, mild burning, temporary bruising or blistering. Hyper-pigmentation** (browning) and **Hypo-pigmentation** (lightening) have also been noted after treatment. These conditions usually resolve within 3-6 months, but **permanent color change is a rare risk.** Avoiding sun exposure before and after the treatment reduces the risk of color change.
Infection: Although infection following treatment is unusual, bacterial, fungal and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a treatment. This applies to both individuals with a past history of herpes simplex virus infections and individuals with no known history of herpes simplex virus infections in the mouth area. Should any type of skin infection occur, additional treatments or medical antibiotics may be necessary.
- 3 **Bleeding:** Pinpoint bleeding is rare but can occur following treatment procedures. Should bleeding occur, additional treatment may be necessary.
- 4 **Allergic Reactions:** In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations have been reported. Systemic reactions (which are more serious) may result from prescription medicines.
- 5 I understand that exposure of my eyes to light could harm my vision. I must keep the eye protection goggles on at all times.
- 6 Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, and hyper-pigmentation.

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

ACKNOWLEDGMENT:

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release _____ (individual) and _____ (facility) and _____ (doctor) from all liabilities associated with the above indicated procedure.

Client/Guardian Signature _____ Date _____

Laser Technician Signature _____ Date _____

CONSENT FORM
for PHOTOFACIAL/SKIN REJUVENATION and/or NON-ABLATIVE WRINKLE REDUCTION

I _____, consent to and authorize _____ to perform treatments on me. Light can be used effectively to destroy targets located in the skin with minimum damage to the surrounding tissues. Light is used to lighten, fade or remove photo-damaged skin in a nonablative manner, a procedure known as *photo rejuvenation*. Visible signs of photo damage include wrinkling, enlarged pores, coarse skin texture, and pigment alterations.

Photo-therapy, despite its high levels of efficacy and safety, is not free of side effects. Erythema (redness) and edema (swelling) of the treated area can occur but usually subsides within a few hours but can last up to seven days or longer. Irritation, itching, and/or a mild burning sensation or pain similar to sunburn may occur within 48 hours of treatment.

Pigmentary changes such as hyper pigmentation and hypo pigmentation of the skin in the treated areas can occasionally occur. Mostly it is transient, lasting up to six months, but in rare cases it can be permanent. Most cases of hypo- or hyper-pigmentation occur in people with darker skin or when the treated area has been exposed to sunlight before or after treatment. Occasionally these pigmentary changes occur despite appropriate protection from the sun.

Scarring, which can be hypertrophic or even keloid, is very rare but can occur. Other known complications of this procedure include blisters, reddening, pinpoint pitted scars, bruising, superficial crusting, burns, pain, and infections. These side effects are usually temporary, lasting from five to ten days but can be permanent as well.

The skin at or near the treatment site may become fragile. If this happens, makeup should be avoided and the area should not be rubbed, as this might tear the skin. A blue-purple bruise may appear on the treated area, which might last from five to fifteen days. As the bruise fades, there may be rust-brown discoloration of this skin, which fades in one to three months or longer.

Additionally, there is a known and expected loss of hair in the treated areas. In a very small percent of people there is new hair growth in the surrounding areas being treated.

Even though appropriate measures are taken to reduce side effects, they cannot be completely eliminated in every case. I understand that the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks. There may be other treatment options, such as injections, other types of lasers/light sources or peels. With this in mind, I am choosing this non-invasive treatment for vascular and/or pigment lesions and other indicated skin conditions.

Eye damage can occur from the light and therefore protective eyewear must be worn during all phototherapy sessions.

I have read and understand the Pre and Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre and post procedure guidelines are crucial for healing, prevention of scarring, and other side effects and complications such as hyper pigmentation, hypo pigmentation, and other skin textural changes.

I understand that this examination is not meant to replace the necessity for a complete dermatological examination.

Photographs: I give permission for my photographs to be used to help document my treatment course. Complete confidentiality will be maintained.

No guarantee, warranty, or assurance as been made to me as to the results that may be obtained. I am aware that follow-up treatments may be necessary for desired results. Most patients require a number of treatments

over several months with gradual results occurring over this time. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for treatments received.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

I release _____, medical staff, and specific technicians from liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age. This Consent Form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

Note: All prices are subject to change without prior notice.

CLIENT SIGNATURE _____ **Date** _____