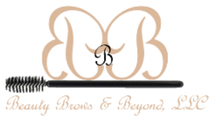

Advanced Facial Treatments Client Consent Form

SECTION 1: MEDICAL HISTORY FORM/HEALTH QUESTIONNAIRE

Date___________ Birth Date_______________________ Age______ DL or ID# _____________________
Name: ____
Address: __________________________________City_________________State______Zip______
Phone #________________________Email____
Emergency contact person________________________________Phone#_____________________

Have you had any of the following procedures, suffer from the following diseases/conditions, or are taking any of these medications? (Circle YES or NO)

YES/NO	Autoimmune disorder or connective tissue disease	YES/NO	Pacemaker
		YES/NO	Piercings
YES/NO	Accutane/Retin-A within year	YES/NO	Phlebitis
YES/NO	Allergies	YES/NO	Previous Facial Treatments
YES/NO	Chemotherapy/Radiation within the past 6 months?	YES/NO	Skin Cancer
		YES/NO	Sensitive Skin
YES/NO	Eczema/Psoriasis/dermatitis	YES/NO	Skin Cancer
YES/NO	Extremely Oily Skin	YES/NO	Sun Burn
YES/NO	Heart Conditions	YES/NO	Recent use of topical agents such as glycolic acids, alpha-hydroxy acids and Retin-A
YES/NO	High/Low Blood Pressure		
YES/NO	Irritated or Broken Skin		
YES/NO	Migraines	YES/NO	Vascular Lesions
YES/NO	Metal Implants (plates, screws, pins)	YES/NO	Varicose Veins/Thrombosis
YES/NO	Pregnant/Breast Feeding	YES/NO	Stroke/TIA
YES/NO	Recent Chemical Peels	YES/NO	Skin irritation
YES/NO	Light Sensitivity	YES/NO	Wear contacts or glasses

SECTION 2: ACKNOWLEDGMENTS, AGREEMENTS, RISKS, AND, CONSENT

Please initial before each statement to accept your acknowledgement and agreement to the following:

______ I understand there are certain contraindications that would preclude me from receiving ultrasonic and or high frequency treatments, including autoimmune disorders, diabetes, embolism, epilepsy, melanoma, metal implants including plates/pins/screws, open wounds, pacemaker use, phlebitis, pregnancy, thrombosis, and varicose veins.

_____ I understand that the use of Botox®, Juvederm®, Restylane®, and any other injectable must be disclosed prior to treatment.

_____ I understand that ultrasonic or high-frequency treatments involve conducting mild electrical currents through the body, and that this brings some inherent risk.

_____ I understand that reactions are rare, but may include nausea, dizziness, weakness, and possible skin reactions including redness and/or other irritations.

_____ I understand that some clients report slight tingling sensations, flashing of the optic nerve, and/or a metallic taste in the mouth during the procedure.

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_____ I understand that while the goal of this treatment is to improve the vitality of the skin, no specific guarantees of the result can or have been made.

_____ I understand that it is imperative to my health that I disclose all of the information requested in the Client Profile/Health History.

_____ I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.

_____ I understand that additional conditions could occur or be discovered during the procedure which could affect my ability to tolerate the procedure.

_____ I consent to "before and after" photographs for the purpose of documentation, potential advertising and promotional purposes.

I understand that if I have any concerns, I will address these with my esthetician. I give permission to esthetician to perform the ultrasonic or high-frequency procedure we have discussed, and will hold him/her and his/her staff harmless and nameless from any liability that may result from this treatment. I have accurately answered the questions above, including all known allergies, prescription drugs, conditions, or products I am currently ingesting or using topically. I understand my esthetician will take every precaution to minimize or eliminate negative reactions as much as possible. In the event I may have additional questions or concerns regarding my treatment, I will consult the esthetician immediately. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the esthetician responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

Client Name (printed) ____

Client Name (signature) _______________________________________Date_______________________________

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<u>HIGH FREQUENCY POST CARE</u>

- Use an SPF on your face to protect it after any advanced facial.
- Avoid extreme temperatures- the wind, effects of central heating as this can have a dehydrating or damaging effect on the skin and your skin may be more vulnerable straight after an electrical treatment.

<u>ULTRASONIC POST CARE</u>

- Use an SPF on your face to protect it after any advanced facial.
- Avoid extreme temperatures- the wind, effects of central heating as this can have a dehydrating or damaging effect on the skin and your skin may be more vulnerable straight after an electrical treatment.

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