BEAUTILASE

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Consent Form GREEN PEEL

Today's Date_____

CLIENT INFORMATION & MEDICAL HISTORY INFORMED CONSENT In order to provide you with the most appropriate treatment, please complete the following questionnaire. All information is strictly confidential.

Name _____ DOB ____/____/____ Age _____ Sex _____

Address _____ City _____

Cell Phone _____ Home Phone _____

E-Mail Address _____ How did you hear about us? _____

Area To Be Treated _____

Medical Information: Do you have any of the following medical conditions? (Please TICK all that apply)

__ Cancer ___ Vitiligo ___ Hepatitis

__ Diabetes ___ Pacemaker/Defibrillator ___ Hormone Imbalance

__ High Blood Pressure ___ Paralysis ___ Thyroid Imbalance

__ Herpes Simplex ___ Muscle Weakness ___ Blood Clotting Disorder

__ Frequent Cold Sores ___ Neurological Disorder ___ Keloid Skin Lesions

__ HIV/AIDS ___ Arthritis ___ Eczema

__ Depression ___ Seizure Disorder ___ Psoriasis

__ Auto- Immune Disorder

Are you currently under the care of a Physician or Dermatologist? Yes / No If yes, Provide Details

_____

Do you have any other current of past health problems or medical conditions? Yes / No If yes, Provide Details

_____

Please list any known allergies, and/ or past allergic reactions:

_____

Have you had any surgeries? Yes / No If yes, Provide Details

_____

Current Medications Please list all oral and topical medications you are presently taking: (including anti-biotics, hormone therapy, blood thinners, mood altering medications, 'over the counter' medications)

_____

_____

Please list all vitamins and/or herbal supplements you are presently taking:

_____

Have you ever had any of the following?

__ Laser Hair Removal	___ IPL Treatment	___ Photofacials	___ Fractional Laser
__ Electrolysis	___ CO2 Laser	___ Lase Surgery	___ Cosmetic Surgery
__ Waxing	___ Collagen or Other Fillers	___ Botox or Dyspot	___ Facials
__ Tweezing	___ Chemical Peels	___ Microdermabrasion	___Threading

Are there any other laser or skincare treatments you are interested in:

_____

_____

Client Lifestyle

Do you smoke? _____ How often? _____

Do you drink? _____ How often? _____

Are your activities mostly indoor or outdoor? Circle one.

How many times a week do you exercise? _____

Do you use tanning beds? Yes / No

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

Have you recently used any self-tanning lotions of spray tans/treatments? Yes / No

For our female patients only:

Are you currently on Birth Control? Yes / No

Are pregnant or lactating? Yes / No

Are you trying to become pregnant? Yes / No

Are you nursing? Yes / No

Did you get hyperpigmentation or pregnancy mask during your pregnancy? Yes / No

Are you menopausal? Yes / No

When was the last day of your last menstrual period? _____

I understand that BEAUTILASE will use/ and or disclose my personal health information for the sole purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations.

I hereby release, BEAUTILASE from any liability arising out of the services associated with the above treatment. I certify that the preceding medical, personal, and skin history are true and correct. I am aware of the above stated BEAUTILASE policies and will abide by them. I am aware that it is my responsibility to inform BEAUTILASE of any medical changes, health changes, skincare regimen, new or changed medications, or recent sun exposure as this will alter the results of my treatment. A current medical history is essential for the caregiver to execute the appropriate treatment procedures.

My expectations are realistic and I understand that the results are not guaranteed and that for maximum results, more than one application may be required. The rate of improvement of my skin depends on my age, skin type and condition, degree of sun/environmental damage, pigmentation levels, or acne condition.

I understand that this procedure is expected to make the skin feel uncomfortable while being applied, but agree to inform the skin professional immediately if I have concerns or am overly uncomfortable during treatment or after I return home.

I agree that I am willing to follow recommendations by BEAUTILASE for home care. I will be responsible for following home regimens that can minimize or eliminate possible negative reactions, including recognizing the importance of adhering to a sunscreen and avoiding the sun/tanning booths and extreme weather conditions. I agree to use a moisturizer specifically recommended by beauty therapist and I acknowledge that I have been informed of the possible negative reactions (intense erythema and pigmentation) and the expected sequence of the healing process (dryness, irritation, redness, and peeling of the skin). In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult my therapist immediately.

I UNDERSTAND AND ACKNOWLEDGE THAT PAYMENTS FOR THE ABOVE TREATMENTS ARE NON REFUNDABLE AND NON EXCHANGEABLE. THIS INCLUDES ANY PACKAGE DEALS WE OFFER.

Client Signature: _____ Print Name:_____ Date:_____

Therapist: _____ Print Name:_____ Date:_____