ADVANCED SKIN PROCEDURES

DERMAPLANING | MICRONEEDLING | MICRODERMABRASION | PHOTO-LIGHT FACIAL

NAME: _____ **BIRTHDAY:** _____

ADDRESS: _____

CITY STATE ZIP

EMAIL: _____ **PHONE #:** _____

EMERGENCY CONTACT NAME: _____ **PHONE #:** _____

HOW DID YOU HEAR ABOUT US? _____

(IF REFERRED BY ANOTHER CLIENT, PLEASE PROVIDE THEIR FIRST AND LAST NAME)

DO WE HAVE PERMISSION TO USE ANY PHOTOS OR VIDEOS TAKEN FOR MARKETING PURPOSES? ☐ **YES** ☐ **NO**

MEDICAL INTAKE

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING INCLUDING TOPICAL PRESCRIPTIONS OR SUPPLEMENTS (ASPIRIN, HERBALS, FISH OIL, ETC.):

☐ Retin-A ☐ Hydroquinone ☐ Differin ☐ Renova ☐ Blood Thinner

☐ Accutane (current or within the past 6 months?): _____

PLEASE LIST ANY ALLERGIES:

ARE YOU CURRENTLY PREGNANT? ☐ Yes ☐ No ARE YOU CURRENTLY NURSING? ☐ Yes ☐ No

PLEASE INDICATE EACH CONDITION THAT APPLIES TO YOU:

☐ Alcoholism
☐ Autoimmune Disease
☐ Cancer
☐ Connective Tissue Disorder
☐ Diabetes
☐ Hepatitis A, B or C
☐ History of Keloid Scarring
☐ Migraines
☐ Multiple Sclerosis
☐ Pigmentation Disorder
☐ Other: _____
☐ Anemia
☐ Bleeding Disorder
☐ Cardiac Abnormalities
☐ Chemical Dependency
☐ Epilepsy / Seizures
☐ Herpes / Cold Sores
☐ History of Eczema, Psoriasis and Other Chronic Conditions
☐ Neuromuscular Disorder
☐ Polycystic Ovaries
☐ Asthma
☐ Breast Lump
☐ Collagen Vascular Disease
☐ Chronic Fatigue
☐ Fibromyalgia
☐ HIV / Aids
☐ History of Actinic (Solar) Keratosis
☐ Pacemaker or Defibrillator
☐ Skin Lesion

HOW OFTEN DO YOU WORK OUTDOORS? ☐ Frequently ☐ Occasionally ☐ Very Rarely

HAVE YOU OR ANY OF YOUR FAMILY HAD SKIN CANCER? ☐ Yes ☐ No If yes, please explain: _____

HOW OFTEN DO YOU USE A SUNSCREEN? ☐ Frequently ☐ Occasionally ☐ Very Rarely ☐ Never

HOW OFTEN DO YOU USE TANNING BEDS? ☐ Frequently ☐ Occasionally ☐ Very Rarely ☐ Never

INTERESTS AND CONCERNS:

☐ Acne
☐ Rosacea
☐ Scars
☐ Oily Skin
☐ Wrinkles
☐ Large Pore Size
☐ Broken Capillaries/Veins
☐ Other: _____
☐ Pigmentation
☐ Brown Spots
☐ Fine Lines
☐ Loss of Skin Tone
☐ Dryness
☐ Discoloration

PREVIOUS PROCEDURES:

☐ Microdermabrasion
☐ Chemical Peels
☐ Botox / Juvederm / Radiesse / Restylane / Fillers If yes, when? _____
☐ Laser Hair Removal
☐ Laser Skin Therapy (IPL/Photo)
☐ Permanent Makeup
☐ Waxing

ADVANCED SKIN PROCEDURES

DERMAPLANING | MICRONEEDLING | MICRODERMABRASION | PHOTO-LIGHT FACIAL

CONTRAINDICATIONS | CLIENT CONSENT

DERMAPLANING is a physical/mechanical form of exfoliation using a specialized dermaplaning blade for the removal of built-up dead skin cells and vellus hair. Following treatment skin will be smoother, softer, and better able to absorb the active ingredients in treatment and home care products.

I understand this treatment involves the use of the sterile, surgical blade to remove dead skin cells and vellus hair. As with the use of any sharp instrument, there is the possibility of nicks or cuts.

I understand there are contraindications to this treatment including, but not limited to, diabetes (not controlled by diet or medication), cancer, active acne, bleeding disorders, the inability for blood to coagulate or the development of keloids following injury. Certain medications including blood thinners, higher dosages of Aspirin, and Accutane are contraindicated for this treatment due to the possibility of delayed clotting from a nick or cut.

I certify that I am not taking any of the above medications or experiencing any of the above conditions.

While every precaution will be taken to avoid nicks, cuts and scratches, I understand the risks and consent to treatment.

SIGNATURE: _____

MICRONEEDLING is a non-surgical and minimally ablative treatment.

Side effects and complications are usually minimal. Following the procedure, the skin will be red and/or flushed in appearance similar to moderate sunburn. You may experience erythema, bleeding, skin tightness, mild sensitivity, or allergic reactions. This will diminish after a few hours following the treatment and within 24 – 48 hours the skin should be healed.

I understand there are contraindications to this treatment including, but not limited to, Active Cold Sore (Herpes Simplex Virus) and Acne, Keloid Scars or Raised Scarring, History of Eczema, Psoriasis, or other chronic conditions, Presence of Raised Moles, Warts or Raised Lesions on Treatment Area, New Scar Tissue/Wounds. Absolute Contraindications include: Scleroderma, Active bacterial or fungal infection, Women who are Pregnant or Nursing.

SIGNATURE: _____

MICRODERMABRASION projects a flow of inert crystals over the skin and abrades away epidermal tissue in the areas treated. It is done so precisely that normal surrounding tissue is hardly affected. Microdermabrasion is often used to treat acne, reduce the appearance of scars, wrinkles, hyperpigmentation, and other skin conditions.

Avoid use of Retin-A, Renova, Alpha or Beta Hydroxy Acid products and all forms of scrubs for 48 hours post treatment. Avoid swimming pools for approximately 1 week. Anytime the skin barrier is broken, there is a small risk of bacterial or viral infection.

Although it is impossible to list every potential risk and complication, the following conditions are recognized as contraindications for microdermabrasion treatment and must be disclosed prior to treatment. Active infection of any type, such as Herpes Simplex Virus or flat warts, active acne, sunburn, recent use of topical agents such as glycolic acids, alpha-hydroxy acids, and Retin-A, uncontrolled diabetes, Eczema, Dermatitis, skin cancer, vascular lesions, oral blood thinner medications, rosacea, pregnancy, use of Accutane within the last year, family history of hypertrophic scarring or keloid formation, or Telangiectasia/erythema may be worsened or brought out by skin exfoliation.

SIGNATURE: _____

THE PHOTO-LIGHT FACIAL works by directing a beam of light to an irregularity in the skin and removes the abnormality without scarring or damage, while stimulating collagen production to tighten the surrounding tissue.

I understand that erythema is a common immediate reaction from this treatment that typically resolves in 2 hours but can last longer. There is a possibility of rare side effects such as blister or swelling that may occur. I understand that 4-6 treatments are required for this treatment to be most effective. I understand that it is important to follow the recommended maintenance schedule for future treatments for best possible results. I also realize that each individual's treatment response may be different; therefore, the number of treatments may vary. I understand sun exposure, tanning beds, sunless tanning lotions, and tanning creams can cause discoloration or a reaction prior to or during the course of laser treatments. A broad spectrum (UVA/UVB) sunscreen of SPF30 or greater should be applied to the area(s) whenever exposed to the sun. I understand that once I have started my treatment program, there are no refunds. I understand that customers with open wounds, malignant skin tumors, and certain diseases, tattoos, or currently taking Accutane cannot be treated and certify that none of these apply to me.

SIGNATURE: _____

ADVANCED SKIN PROCEDURES

DERMAPLANING | MICRONEEDLING | MICRODERMABRASION | PHOTO-LIGHT FACIAL

CLIENT CONSENT

PLEASE INDICATE THAT YOU HAVE READ THE FOLLOWING:

- ☐ I recognize there are no guaranteed results and that results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further facials to obtain the expected results at an additional cost. After the facial, in rare cases, the skin will be pink and flushed in appearance. I may also experience skin tightness and mild sensitivity to touch or sweating on the facial area.
- ☐ I understand that results will vary between individuals. I understand that although I may see a change after my first facial, I may require a series to obtain my desired outcome. I understand that a Facial is a cosmetic treatment, not a medical procedure.
- ☐ The facials and any potential contraindications or side effects have been explained to me to my complete satisfaction.
- ☐ I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the success, or any other result of the Facial, and I hold Remedi Elite Day Spa LLC and my skin care professional harmless for any undesired effect.
- ☐ I state that I have read and understand this consent and I understand the information contained in it. I have had the opportunity to ask any questions about the facials including risks or alternatives and acknowledge that all my questions about the facials have been answered in a satisfactory manner.

BY SIGNING BELOW, I AGREE TO THESE TERMS AND THAT THE ANSWERS ARE VALID FOR ALL FACIALS I RECEIVE AT REMEDI ELITE DAY SPA LLC.

SIGNATURE: _____ **DATE:** _____

POLICIES AND PROCEDURES

IN ORDER TO ASSURE THE BEST CARE TO OUR CLIENTS AND STAFF, PLEASE BE AWARE OF THE POLICIES AND PROCEDURES LISTED BELOW.

ARRIVAL: We request that you arrive approximately 15-30 minutes prior to your scheduled aesthetic treatment. Late arrivals will render the remainder of the scheduled service(s).

SCHEDULING APPOINTMENTS: To hold your appointment, a credit card is required at the time of scheduling. Additionally, payment is required when scheduling online.

CANCELLATION POLICY: You will be emailed, called and/or texted to confirm 1-2 days prior to your appointment. As a courtesy to our clients and staff, it is company policy for all clients to give a 24 hours' notice of cancellation. Failure to do so will result in a 50% charge of your scheduled treatment(s). Clients who miss their appointments without giving any prior notification will be charged in full for the missed treatment(s).

GRATUITY: Gratuities may be paid in cash or charged to your credit card upon request. The amount you leave is at your discretion however, 15-20% is customary.

REFUNDS: Services are final sale. Gift cards and laser packages are non-refundable but may be transferrable. All jewelry is final sale. Skin care and body care products are returnable within two weeks of purchase with a receipt.

BY SIGNING BELOW, I AGREE TO THE TERMS OF THESE POLICIES AND PROCEDURES.

SIGNATURE: _____ **DATE:** _____