SOUTH BAY LIPO LIGHT

FACIAL TREATMENT INTAKE FORM

Your success is our #1 priority.

Help us to help you achieve that success by filling out this questionnaire as completely as possible.

Name**:**_____Date**:**_____

Address**:**_____

City, State & Zip**:**_____

Home **#:**_____ Work **#:** _____ Cell **#:**_____

Email**:** _____Age:_____ Sex:____

Occupation:_____Marital Status:_____

Are you stressed? (Y/N) Cause of Stress: _____
List any current or previous medical conditions that might affect you having this treatment
_____

Do you have any of the following? (Any of the following would make you unsuitable):

____ Pregnant or Breastfeeding
____ Thyroid Problems
____ Light Sensitivity
____ Light Sensitivity
____ Taking Antibiotics
____ Wear Contacts

Medical History (Circle any that apply):

Acne, Any Active Infection, AIDS/HIV, Allergies, Arthritis, Autoimmune Disease, Blood clot abnormalities, Broken Capillaries, Cancer, Carcinoma, Cold Sores, Dermatitis, Diabetes, Eczema, Hepatitis, Herpes Simplex, Hormone Imbalance, HRT, Implants, Injectable, Keloid Scarring, Metal in Body, Pacemaker, Permanent Make-up, Photosensitivity, Tattoos, Telangiectasia, Thyroid Imbalance

Skin Condition

Are you currently under the care of a physician? (Y/N)
For What _____
Are you currently under the care of a dermatologist? (Y/N)
For What _____
What bothers you about your skin?_____
Current Skincare Products used _____
Circle any of the following products currently being used by you

Retin A: How Often ____ Where Applied_____
Accutaine: How Often ____ Where Applied_____
Glycolic AHA: How Often ____ Where Applied_____

Any skin reaction to the above _____

Have you ever had a reaction to any products (if yes, describe)? (Y/N)

_____

Have you had a peel before? (Y/N) If yes, when? _____ What Type _____
Describe skin reaction to the peel _____

Please circle the following Yes or No

Do you smoke? (Y/N)
Is your skin Sensitive or Resilient? (Y/N)
Do you wear permanent makeup? (Y/N)
Have you recently used self-tanning lotions?(Y/N)
Do you go to tanning booths? (Y/N) Have you tanned within last 4 weeks? (Y/N)
Do you currently have sunburn or windburn? (Y/N)
Do you get thick or raised scars from cuts or burns? (Y/N)
Do you have hyperpigmentation (darkening of the skin)? (Y/N)
Describe _____
Do you have hypopigmentation (lightening of the skin)? (Y/N)
Describe _____
Have you had any filler injections within the last 7 days? (Y/N)
Do you use depilatory creams or Wax? (Y/N)
Are you taking any topical prescription creams or ointments? (Y/N)
Have you recently had Botox or any dermal filler? (Y/N)
Cups of Water you drink per day? _____

Have you ever had an allergic reaction to the following? (Circle and describe)

Aloe Vera, Apples, Aspirin, Citrus, Food, Grapes, Hydrocortisone,
Hydroquinone(or skin bleaching), Latex, Lidocaine, Other
Describe Reaction _____

Have you had any recent facial surgeries? (Y/N)
If yes, Describe Reaction _____
Have you had an unpleasant reaction after a facial treatment? (Y/N)
If yes, Describe Reaction _____
Are you undergoing any laser or IPL treatment? (Y/N)
If yes, Describe _____
Are you prone to cold sores? (Y/N) If yes, taking medication? (Y/N)

Are you taking any of the following medications? (Circle and describe)

Accutane, Anti-depressants, Antiviral, Aspirin, Cortisone, Coumadin, Dilantin, Estrogen, Herbs,
Medications, Minerva, Minoxidel, Progesterone, Spironolactone, Testosterone, Tomoxfin,
Other Medication _____

How did you find us? _____
Who may we thank for the referral? _____
Is there anything relevant that you need to let us know? _____

Skin Description (Check all that apply)

Dry __ Normal __ Combination __ Acne __ Oily __ Occasional Breakout __

Thick __ Thin __ Firm __ Saggy __ Sun Damage ___ Rosacea __

What improvements would you like to see in your skin?

_____

_____

Circle the most important element in deciding to use our services (check one):

___ Effectiveness (your results)
___ Time (how fast you get results)
___ Service (how we respond to your needs)
___ Affordable (what we charge)

You should note that if the esthetician is unable to explain to you the contra indications or is unsure of anything that may apply to a specific condition then they should not treat you without asking you to consult with your primary physician. It is your responsibility and not that of Lipo Light South Bay staff to consult your primary physician if necessary. I hereby indemnify the esthetician and Lipo Light South Bay against any adverse reaction sustained as a result of the treatment and confirm that all the information I have given regarding medical, personal, and skin history statements are true and correct are correct, and that it is my responsibility to inform the esthetician performing this procedure, of my current medical and health conditions. *By signing this, you also acknowledge there is a strict 24 hour cancellation policy.*

Signed..... Date...../...../.....

LIPO LIGHT SOUTH BAY OFFICE ONLY Initial Consult Date: _____

Last Name _____ First Name _____ F M

Sessions Purchased _____

Adequate Water Intake (Y/N)
Concerns _____

_____

Lipo Light South Bay FACIAL TREATMENT Consent and Release Form

Name: (First) _____ (Last)_____ DOB _____

Program and Background

If you have requested to be treated with a Facial treatment, you understand that this is a cosmetic treatment. The intended use for the Facial is to aid in the battle of anti-aging by diminishing the appearance of fine lines and wrinkles, improving the texture and appearance of the skin, re-educating and toning facial muscles, and reducing the overall visual appearance of aging. It is a popular non-invasive service that gives you the freedom to attain anti-aging goals without the recovery, downtime, and expense of surgeries. The purpose of this document is to make you aware of the nature of this product and its risks in advanced so that you can decide whether to go forward with this procedure.

Procedure

Initially you will consult with the therapist to determine if you are a candidate any facial treatment. During this time you will have the opportunity to ask questions or voice concerns you may have regarding this treatment. If it is determined you are a candidate for this procedure, there will be a few preliminary steps consisting of: initial paperwork, pre and post treatment photos and suggested course of treatment. It is recommended that a patient will need a multiple treatments (6 to 12) for most facial treatments to achieve its desired effect over a period of four to eight weeks. This treatment should be used in conjunction with a good skin care as results will happen faster and be more dramatic if used with a high quality anti-aging or moisturizing skin care product. These treatments are considered safe, and chances of irritation or side effects are rare.

Risks/Discomforts/Warnings

Facial treatments are safe and has been used for years in numerous medical procedures, spas, the offices of aestheticians and dermatologists and consumers around the world. Always rest during the treatment. (a) If you are having microchannelling (b) If you are pregnant or taking medication (such as Tetracycline) which causes light sensitivity, you should consult your physician before using getting treated. Prior to receiving treatment, you have been candid in revealing any condition that may have bearing on this procedure, such as: pregnancy, nursing (if so, consult your physician prior to treatment), recent facial surgery, allergies, tendency to cold sores/fever blisters, use of Retin-A/Renova, Accutane, Differin, Minocycline, Tazorac or any products that contain Glycolic acid.

Benefits

The treatments offered are reputed to increase blood flow, encourage lymph draining (clearing toxins from tissue), stimulate cellular renewal, and promote the production of both collagen and elastin, the elements that help face to retain its shape. Results include reduced appearances of fine lines and wrinkles, improved skin texture, better facial circulation, and a youthful “glow” to the face.

Consent

This is a strictly a voluntary cosmetic procedure. No treatment is necessary or required but has has been chosen. I have reviewed this consent form. My consent and authorization for this procedure are strictly voluntary. By signing the informed consent form I grant authority for South Bay Lipo Light to perform the described treatment. The purpose of this procedure, risks, complications, alternative methods of treatment have been fully explained to my satisfaction.

_____Initial

I understand that a minimum of 6 to 12 treatments of any facial treatment is required to achieve full results and that this is a cosmetic procedure. At that point, I will be re-evaluated to see if more sessions are needed in order to achieve realistic goals.

I understand that there are contra-indications and I have been informed not to receive this treatment if I have any electrical device implanted, diabetic, thrombosis, epileptic or pregnant. I understand that possible side effects include, but are not limited to skin tightness, and redness. I understand that the results of this treatment may vary due to conditions such as age, condition of skin, sun damage, damage due to smoking, climate, etc. I understand that any injections (Botox, restylane, steroids, cortisone, etc.) should be avoided for 10-14 days before or after this treatment, and that a minimum SPF 30 sun block protection should be used. I understand there may be some degree of discomfort: i.e., stinging, pin-pricking sensation, hotness, or tightness. I understand there are no guarantees as to the results of this treatment, due to many variables, such as: age, condition of skin, sun damage, smoking, climate, etc. I understand I may or may not actually peel, that each case is different. I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied. I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the doctor/technician who performed the treatment. I agree to refrain from tanning while I am undergoing treatment and that the use of sun block protection with a minimum of SPF 30 is mandatory.

_____Initial

No guarantee has been given by anyone as to the results that may be obtained by this treatment. I have read this informed consent and certify that I understand its contents in full. I have had enough time to consider the information and feel I am sufficiently advised to consent to this procedure. I herby give my consent to have this procedure. If at any time during the Microcurrent procedure I experience pain or discomfort of any kind, I agree to inform the staff immediately and/ or terminate the session at my discretion.

The undersigned assumes all responsibility for behavior of self and their clients and agrees to abide by all Rules and Procedures of the property. The clients and all persons on the premises by invitation of the clients herby hold Lipo Light South Bay , its employees, the Corporation or any individual connected in any way to Lipo Light South Bay, harmless for any responsibility or liability for any accident, injury illness or damages sustained by or to any person or their personal property during their treatment appointments or use of facilities. Lipo Light South Bay shall be indemnified and held harmless by the clients, and clients agree to pay all costs incurred in connection with any accident, injury illness or property damage loss, including attorney's fees, regardless of how it may have occurred.
The undersigned hereby releases and indemnifies Lipo Light South Bay and holds harmless any employee, the Corporation or any individual connected in any way to Lipo Light South Bay for any loss of personal property and/ or accident causing personal injury of any nature, including reasonable attorney's fees and court costs in connection therewith. Any photos taken will be used to show the clients progress and may be used in marketing ads.

Cancellation Policy

South Bay Lipo Light requires a 24 hour cancellation notice. Due to demand for treatments, we schedule all appointments following the initial consultation. South Bay Lipo Light reserves the right to refuse service to anyone.

Initial the following

* If I cancel within 24 hours of a reserved session, I will lose or forfeit my session

_____Initial

* If I cancel within 24 hours of a reserved session, I might incur a $35 no-show fee from Schedulicity

_____Initial

* If I fail to show up or am more than 5 minutes late, I will lose or forfeit my session due to staff wages and fees paid for my session, and to avoid inconveniencing other clients scheduled after me

_____Initial

Our cancellation policy has been created to ensure our loyal clients are not disturbed by the tardiness of clients who do not show up on time, or who cancel without a valid reason within 24 hours of an appointment. When reserved sessions are unattended, this means that loyal clients missed the opportunity of having that particular time period. Thank you for your understanding.

Purchase and Reservation Policy

Sessions will only be confirmed and allowed up to the amount of pre-paid sessions. All sales are final and non-refundable. South Bay Lipo Light reserves the right to terminate any client's session, package, or contract, without refunding any monies, if the client has broken any terms or policies. All purchases are final, non-refundable and non-transferable.

* I understand if I have purchased and pre-paid for a first-time Customer Promotion, that I may not use or purchase another first-time Promotion without consent from Lipo Light South Bay first

_____Initial

I understand that it is my personal responsibility to inform the therapist of any changes to my medical history during the course of facial sessions and I confirm that should this occur I shall advise the technician of any changes. I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form. I further state that I am of lawful age and legally competent to sign this aforementioned release; I understand the terms herein is contractual and not a mere recital; I have signed this document of my own free act. By signing this I agree to release my "Before" and "After" pictures which may be used for marketing purposes. Pictures will be without names.

I further state that I am of lawful age and legally competent to sign this aforementioned release. The procedures, alternatives and risks have been explained to me and I have been given the opportunity to ask questions. I understand it is my responsibility to inform the Lipo Light staff is there are any changes to my medical history. I understand the terms herein is contractual and not a mere recital. I have signed this document of my own free act.

_____ _____

Client Date

_____ _____

Parent or Guardian (if under 18 years of age) Date

_____ _____

Lipo Light South Bay Management Date