SOUTH BAY LIPO LIGHT

FACIAL TREATMENT INTAKE FORM

Your success is our #1 priority.

PLEASE ANSWER ALL QUESTIONS

Help us to help you achieve 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 could make you unsuitable):
___ Pregnant or Breastfeeding
___ Thyroid Problems
___ Light Sensitivity
___ Light Sensitivity
___ Taking Antibiotics

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 _____
Retinol: How Often _____ Where Applied _____
Hydroquinone:How Often _____ Where Applied _____

Any skin reaction to the above _____

Have you **ever had a reaction** to **any products or treatment**? (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? (Y/N)
Is your skin Resilient (strong)? (Y/N)
Do you wear permanent makeup? (Y/N)
Do you wear Contact Lenses? (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)
Are you taking anything with Hydroquinone or Retinol? (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 _____

Are you using a skin lightener, brightener or bleach, or a product with acid in it? (Y/N)
If yes, Describe _____
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 Medications _____

How did you find us? _____
Is there anything relevant (as regards to your skin) 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)

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.

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

LIPO LIGHT SOUTH BAY OFFICE ONLY Initial Consult Date: _____

Last Name _____ First Name _____

Facial Treatment Purchased _____

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 a facial is to help with anti-aging by diminishing the appearance of fine lines and wrinkles. Toning facial muscles and reducing the overall visual appearance of aging without the downtime, and expense of surgeries. The purpose of this document is to make you aware of the nature of this product and its risks so that you can decide whether to go forward with this 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) to achieve the desired effect. 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 have 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. 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, Retinol, Differin, Minocycline, Tazorac or any products that contain Glycolic acid or any other types of Acids.

Benefits

The treatments offered at Lipo Light South Bay 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 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.

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. _____Initial

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 that in the event I get a peel, 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.

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 any 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 holds 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.

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 may lose or forfeit my session and I might incur a $35 no-show fee from Schedulicity. 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 <u>if</u> I have <u>purchased and pre-paid for a first-time Customer Promotion</u>, that I <u>may not</u> use or purchase another first-time Promotion <u>without consent from Lipo Light South Bay first.</u>** _____Initial

I understand that it is my personal responsibility to inform the therapist at every treatment 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. Any photos taken will be used to show the clients progress and may be used in marketing ads.

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

(Complete if getting Dermafrac Treatment)

Lipo Light South Bay DermafracTM (Microchannelling) TREATMENT Consent and Release Form

This consent form is designed to verify that you have been satisfactorily informed and educated with respect to your DermaFracTM skin care treatment, as well as its aftercare, so that you may make an educated decision as to whether to have this procedure performed. Please read and initial each paragraph.

I understand that DermaFracTM is a superficial treatment of the skin and is accomplished by using a machine that uses a hand piece that creates minute micro-channels into the skin. These micro-channels stimulate the body to increase cell turnover and allow for high grade solutions to be delivered deeper into the skin and one of the primary purposes of this procedure is to prepare the skin to accept, and increase the absorption properties of active ingredient rejuvenation products, and or chemicals and that certain Infusion Solutions may be used during this treatment. I understand that the solutions used are generally tolerated very well by most patients; however, there may be irritation to my skin. It has been explained to me and I understand that in order to see significant results these treatments need to be done in a series and in combination with active ingredient skin care products. I acknowledge that immediately after my procedure all treated areas may feel warm and appear sunburned and could feel wind burned. My skin may feel dry and sensitive for several days after the treatment. I acknowledge that compliance to my skin care program will enhance the outcome of my DermaFracTM treatments. This includes the use of SPF 30 sun protection over the treated areas on a daily basis during my treatment series. I also understand that compliance with my after-care instructions will greatly affect my final result. I understand that there can be no guarantee as to how effective the outcome of my treatment(s) will be. There also can be no guarantee that dark discoloration (e.g. hyperpigmentation or melasma), scar tissue, stretch marks, or fine lines and wrinkles will be reduced or fade. It has been explained to me, and I understand, that these conditions will respond much better when part of an overall skincare program.

_____Initial

Acne Patients: It has been explained to me that I may experience a slight acne flare-up, and that my acne condition may temporarily look worse for a few days after a DermaFracTM treatment.

_____Initial

I have read and initialed each paragraph and have been satisfactorily informed of the benefits, risks, and complications in regards to DermaFracTM treatments. I consent to this treatment today and for all subsequent DermaFracTM treatments. Photographs are taken of your skin prior to starting a series of treatments, and again at the completion of your treatments for the purpose of documenting progress being made. I hereby authorize Lipo Light South Bay to take photographs of me before, during, and after my treatment series. Photographs are very helpful for educating other's with conditions similar to your own. Your name is never revealed without your consent. We are asking for your consent to allow us to use your photographs in the interest of medical education, knowledge or research.

_____ _____

Client Name Printed Date

_____ _____

Signature Date