



Skin Care Treatment – Informed Consent

**Please initial each section to indicate that you understand each topic. Do not initial if you desire more information.

Proposed Treatment

A facial starts with an analysis of the skin to look for congestion and general skin type. Once the skin type is determined, the proper cleanser, mask, etc, will then be performed. A mask is then applied and finished with the cleansing, toner, moisture, and application of sunscreen.

Initials: _____

I realize that the practice of skin care including microablation, microdermabrasion, electrolysis, facial toning, laser treatments, etc., is not an exact science and no specific guarantees can or have been made concerning the expected result. I understand that some clients experience more change and improvement than others. In virtually all cases, multiple treatments are required in order to realize a difference.

Initials: _____

During your treatment, light, safe, exfoliating products will be used to improve the appearance of your skin. If you have Herpes Simplex Virus – Type 1, please note exfoliating treatments may cause an outbreak. If you are sunburned, have visible cold sores, or have any irritation, you may be asked to reschedule your appointment.

Initials: _____

After your facial treatment:

- Do not use 'active' products for a full 24 hours after your treatment. Avoid the sun and apply sunscreen as directed.
- You may experience flaking, sensitivity and/or light scabbing on extracted comedones, which is normal and will subside within a few days to reveal improved skin.

Initials: _____

Please indicate your skin type:

Normal/Dry _____ Dry _____ Oily _____

How often do you cleanse your face? _____

How does your skin feel in the middle of the day?

How does your skin feel at the end of the day?

Have you ever had a facial? Yes _____ No _____
If yes, when? _____

Are you using any facial products? Yes _____ No _____

If yes, which ones? _____

Are you under a lot of stress? Yes _____ No _____
Do you have any chronic skin disorders? Yes _____ No _____

If yes, what are they? _____

Are you currently using any medication? Yes _____ No _____
If yes, which medications? _____

Are you allergic to cosmetic ingredients/medications?
Yes _____ No _____

If yes, which ones? _____

Have you suffered from acne? Yes _____ No _____
If yes, please circle: Heavy / Light / Other

Are you using Retin-A? Yes _____ No _____
If yes, what strength? _____ How long? _____
Are you using Accutane? Yes _____ No _____

Do you have any facial scarring? Yes _____ No _____
If yes, which region? _____

Have you had any prior cosmetic peels? Yes _____ No _____
If yes, when? _____

Are you currently pregnant? Yes _____ No _____ Do you currently take oral contraceptives? Yes _____ No _____
If yes, which one? _____

Do you currently take hormones? Yes _____ No _____

I understand that the following risks and hazards may occur in connection with any particular treatment, including, but not limited to: unsatisfactory results, poor healing, discomfort, redness, blistering, nerve damage, scarring, infection, change in the skin pigmentation and increased hair growth. I understand that even though precautions may be taken in my treatment, not all risks can be known in advance.

Initials: _____

Cost/Fees

Payment for this cosmetic procedure is my responsibility. I understand that there will be an additional fee if I should want/need maintenance or follow-up visits.

Initials: _____

I have read and fully understand this consent and my questions have been answered satisfactorily by Allure associates. I accept the risks and complications of the procedure.

Initials: _____

I agree not to hold Allure MedSpa or any of its representatives responsible for any adverse effects resulting from the Sapphire 3 treatment.

Initials: _____

Patient Signature Date

Patient Name (Print) Date

Witness Signature Date