INFORMED CONSENT FORM

Client/Patient Consent to Treatment:

My signature acknowledges that I have read and agree to receive the following treatments or series of treatments listed below:

I, _____ consent to and authorize Women's and Family Care to perform skin exfoliation, skin waxing, facials, body treatments, eye lash extensions, spray tanning, laser hair removal and other related skin care services.

Services:

- I have not used a scrub, Retin A, take home microdermabrasion, or chemical peel in the last 72 hours._____ (Initial)
- The nature and purpose of the treatment have been explained to me and any questions I may have regarding this procedure have been explained to my satisfaction._____(Initial)
- I understand that with any treatment certain risks are involved and that any complications or side effects from know or unknown causes could occur. I freely assume these risks._____(Initial)
- I am not Epileptic and do not have heart or circulation problems._____(Initial)
- Possible side effects include but are not limited to mild redness extreme redness bruising occasional swelling blistering stinging tenderness dry skin flaking lightening or darkening of the skin infections pimples bumpy appearance and cold sores. Most side effects are temporary and generally fade within 72 hours._____ (Initial)
- If prone to cold sores see your physician about a prescription for Acyclovir, Zovrax or take supplements of Olive leaf oil. Or lysine along with beta carotene and folic acid._____(Initial)
- It is recommended to discontinue use of all AHA's, glycolic, retin a renova or any exfoliating products for up to 72 hours post procedure. Use hydrating soothing antioxidants and ice for swelling and inflammation reduction. No sun exposure or tanning beds for 72 hours and use of at least an SPF 15 daily when receiving treatments is recommended. _____(Initial)
- I agree to adhere to all safety precautions and home skin care programs as recommended by Women's and Family Care._____(Initial)
- I am over 18 years of age or I have parental consent co-signed below._____(Initial)
- I will call to inform Women's and Family Care of any complications or concerns I may have as soon as they occur._____(Initial)
- I have been off Accutane for at least 12 months._____(Initial)

Client Signature and Date_____

Co-Signer and Date_____

Witness and Date_____