HYDRAFACIAL CONSENT AND RELEASE FORM

Name ______________________________________ **Date** ____________

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS THAT YOU CURRENTLY HAVE OR HAVE HAD

Accutane or similar prescription acne medication ___
HIV or AIDS ___
Lupus or Autoimmune Disease ___
Pregnant or breast feeding ___
Cold sores, fever blisters ___
Cosmetic injections, fillers etc. (Botox, Juvederm etc.) ___
Eczema, Psoriasis ___
Waxing services within past 7 days ___
Hypertension/high blood pressure ___
Irregular moles, warts, growths on face ___
Laser procedures within the past 4 weeks ___
Microdermabrasion in the past 2 weeks ___
Thin skin on face ___
Pacemaker or metal implants ___
Recent surgical or dental procedure ___
Retin A, Retinol, Renova ___
Stage III or Stage IV acne ___
Sunburn ___
Thyroid condition ___
Under medical care for an existing or suspected
Blood Thinners (Heparin, Coumadin, Warfarin, etc.) ___
Cancer or post cancer treatments ___
Hepititus ___
Cardiovascular problems ___
Cortisone or steroid injections ___
Enlarged or painful glands ___
Epilepsy ___
Heart problems ___
Inflammatory conditions ___
Raised scars, new scars on face ___
Chemical peels within the past 4 weeks ___
Light sensitive medication ___
Lymphatic disorder, inflammation of lymph glands ___
Varicose veins ___
Rosacea ___
Skin abrasions on face ___
Skin lightening or bleaching agents ___
Swollen or infected tonsils ___
Type I diabetes ___
Viral infection or Influenza ___

PLEASE SPECIFY YOUR AREAS OF CONCERN REGARDING YOUR SKIN AND SKIN CARE

____

Please initial each blank spot to acknowledge that you have read and agree with the following statements

1. I acknowledge I have not used Accutane or any prescription acne medication in the last 12 months _____
2. I acknowledge that if I have ever had a cold sore or fever blister I should consult with my physician for a pre-use medication to help avoid a possible breakout. That medication should be used each day for two days before, same day, and two days after any facial exfoliation treatment _____
3. I acknowledge that there is no guarantee that dark discoloration of skin will be reduced or lightened. Pigmentation may improve or darken with successive treatments. I acknowledge the need for a proper home skin care regimen _____
4. I acknowledge that my skin might experience temporary irritation, tightness, redness or slight swelling which usually dissipates within 72 hours depending of sensitivity _____
5. I acknowledge that if I fail to use a minimal sunscreen (SPF 30) I am more susceptible to sunburn, skin damage and hyperpigmentation _____
6. I acknowledge that this procedure is strictly an elective cosmetic procedure and that no medical claims have been expressed or implied.
7. I acknowledge that I should avoid use of non-HydraFacial glycolic products for 2-4 weeks prior and after this Treatment _____
8. I acknowledge that I should avoid use of non-HydraFacial Retin-A type products for a period of two weeks prior and after my HydraFacial treatment _____
9. I acknowledge I am not currently pregnant or breastfeeding _____
10. I hereby agree to have the treatment preformed and agree to follow all pre and post treatment instructions _____
11. I acknowledge that I have answered all questions truthfully and completely _____
12. I realize this is an elective procedure and release the Esthetician, Bella Vita Spa and Salon, Edge Systems Corp. from all liability associated with any injuries and or current or future conditions resulting from the skincare procedure _____
13. I acknowledge that if I have checked any of the above conditions, my Esthetician has explained the risks and I have chosen to have the treatment without any liability to the Esthetician, Bella Vita Spa and Salon or Edge Systems Corp. ___

Signed ____