



Please read carefully, complete, sign and date this form prior to your treatment.

MEDICAL INFORMATION

CHECK ALL THAT APPLY:

- Accutane or similar medication (in the past year)
- Autoimmune disease, HIV, lupus, hepatitis, scleroderma
- Active infection in the treatment area
- Melanoma or lesions suspected of malignancy
- Active sunburn
- Pregnancy
- Breast feeding (may increase skin sensitivity and likelihood of hyperpigmentation)
- Epilepsy (contraindicated for LED light therapy)
- Anticoagulant therapy
- Other aesthetic treatments: Botox: wait 5-7 days; Fillers: wait 7-10 days; Peels: wait 30 days; Retin-A: wait 3 days
- Recent facial waxing
- Laser treatments: wait until lesions heal and swelling and redness are resolved
- Keloids: avoid direct contact
- Rosacea, telangiectasia

If you checked an item above, please explain:

CLIENT CONSENT

(Please initial each acknowledgement line below)

_____ I acknowledge that I have not used Accutane or any medication for the same purpose during the last 12 months.

_____ I acknowledge that if I have ever had cold sores or fever blisters, I should consult with my physician or pharmacist 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 aggressive facial exfoliation treatment.

_____ I acknowledge that there is no guarantee that dark discoloration of skin will be reduced or fade. Pigmentation may improve or darken with successive treatments. I acknowledge the need for proper skin care home regimen.

_____ I acknowledge that my skin might experience temporary irritation, tightness, or redness which usually dissipates within 72 hours depending on skin sensitivity.

_____ I have disclosed my history of allergies above.

_____ I acknowledge that if I am allergic to one or more of the ingredients in the products used, I may experience allergic reactions.

_____ I acknowledge that if I fail to use a minimal sunscreen (SPF 30) and follow the direction for use, I am more susceptible to sunburn, sun damage & hyperpigmentation. I should avoid excessive sun exposure, especially between 10am- 2pm.

_____ I acknowledge that this treatment is strictly an elective cosmetic procedure and that no medical claims have been expressed or implied.

_____ I acknowledge that I should avoid use of aggressive exfoliation, waxing, and products containing acids that are not part of the recommended take-home regimen for 2-4 weeks following the treatment.

_____ I acknowledge that I should avoid use of Retin-A type products for a period of time recommended by my physician and/or skincare practitioner during and following the treatment.

_____ I acknowledge that I am not pregnant/lactating.

_____ I hereby agree to have the treatment performed and agree to follow all pre and post treatment instructions.

_____ I acknowledge that I have answered all questions truthfully and completely.

_____ I release Edge Systems, the Aesthetician, and management and staff of Salt MedSpa from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products.

_____ I consent to the use of my before, during and after facial procedure photographs for education, promotion or advertising purposes. My name will not be used to identify these photographs without my written approval.

By signing below, I certify that I read and fully understand the contents of this consent form, and that the information I provided above is complete, accurate, and up-to-date to my knowledge.

Client Signature: _____ Date: _____

Client Printed Name: _____ Staff initial: _____