

HYDRAFACIAL™ TREATMENT CONSENT FORM

HydraFacial is the only hydradermabrasion procedure that combines cleansing, exfoliation, extraction, hydration and antioxidant protection simultaneously, resulting in clearer, more beautiful skin with little-to-no downtime. The treatment is soothing, moisturizing, non-invasive and generally non-irritating. As with most procedures, visible results from HydraFacial will vary from person to person.

What to expect:

- Your skin may experience temporary irritation, tightness, or redness. These are all normal reactions that typically resolve within 72 hours depending on skin sensitivity.
- You may experience tingling and stinging in the treatment area. These sensations generally subside within a few hours.
- Client experiences may vary. Some clients may experience a delayed onset of these symptoms.
- You will likely see results immediately after treatment and your skin may feel smooth and hydrated for one to four weeks with appropriate home care to maintain treatment results.
- The skin is more susceptible to sunburn/sun damage. Avoid excessive sun exposure and use a minimum of SPF 40 sunscreen.

Do you have any of the following?*

- | | | |
|--|------------------------------|-----------------------------|
| Active acne or infection _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Open lesion or cold sore _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| An active infection in the treatment area _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Active sunburn _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Skin conditions such as eczema, dermatitis, or rashes _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| An autoimmune disease such as lupus _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| A viral concern such as HIV or hepatitis _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Anticoagulants Therapy _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Melanoma or lesions suspected of malignancy _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Pregnancy or lactation _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Neurological disorders such as epilepsy (LED Lights) _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Infection in the urinary system i.e. kidneys, bladder and urethra (Lymphatic drainage) _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Crohn's Disease (Lymphatic drainage) _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hyperthyroidism (Lymphatic drainage) _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Deep Venous Thrombosis (Lymphatic drainage) _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lymphedema (Lymphatic drainage) _____ | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

*Saying yes does not preclude you from receiving treatments.



Have you recently?

- Used Accutane, topical medications or antibiotics _____ Yes No
- Had aesthetic fillers, injectables or laser treatments _____ Yes No

I acknowledge the following:

- I will avoid the use of aggressive exfoliation, waxing, and products containing glycolic acids or retinols that are not part of the recommended take-home regimen in the treated areas for minimum 2 weeks pre- and post-treatment.
- Photos may be taken before, during and after the HydraFacial treatment. Photos will only be used with my written approval for education, promotion or advertising purposes.
- The information provided has been explained to me and all my questions have been answered to my satisfaction. I have read the above information, and I give my consent to have the HydraFacial treatment by the staff at _____.
- By signing below, I acknowledge that I have read the above information and give my consent to be treated with the HydraFacial System. This consent form is valid for all future HydraFacial treatments. I will alert the staff if there are any future changes to my medical history.

Print name: _____ Signature: _____ Date: _____

