



PATIENT CONSENT FORM FOR WAXING

Contraindications

Caution urged

Broken skin
Inflammation
Diabetes
Suspicious growths
Accutane (last six months)
Active herpes

AHAs, Retin-A, Renova (discontinue use 48
use 48 hours prior to treatment)
Flat moles
Phlebitis
Fragile capillaries

Please mark all of the above that apply to you.

I understand that following the waxing procedure, I should:

- Apply a sunblock with an SPF of at least 15
- Avoid use a loofah or other abrasive to the waxed area
- Avoid saunas, steam rooms, Jacuzzis or other heat sources
- Avoid application of Retin - A, Renova, or AHA products for 48 hours.

Please note that waxing has certain side effects such as skin removal, redness, swelling, tenderness, etc.

I have read the above information and if I have any concerns, I will address these with my esthetician. I give permission to my esthetician to perform the waxing procedure we have discussed and will hold her and her staff harmless from any liability that may result from this treatment. I have given an accurate account of the questions asked above including all known allergies or prescription drugs or products I am currently ingesting or using topically. I understand my esthetician will take every precaution to minimize or eliminate negative reactions as much as possible.

I have read and understand the post-treatment home care instructions. I am willing to follow recommendations made by my esthetician for a home care regimen that can minimize or eliminate possible negatives reactions. In the event that I may have additional questions or concerns regarding my treatment or suggested home products/post-treatment care, I will consult the esthetician immediately.

I agree that this constitutes full disclosures, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand the procedure and accept the risks. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

ACKNOWLEDGMENT

I UNDERSTAND AND ACKNOWLEDGE THAT PAYMENTS FOR THE ABOVE PROCEDURE ARE NON-REFUNDABLE.

BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS PERMISSION FORM FOR TREATMENT OF WAXING AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.

Signature-Patient or Guardian

Print Name/Relationship

Date

Signature-Witness

Date