CLIENT CONSULTATION AND RELEASE FORM
Please read carefully, complete, sign and date this form prior to your procedure.

Name: _____
Phone: (_____)_____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____

☐ HydraFacial®
☐ BLUE/RED LIGHT THERAPY
☐ LYMPHATIC/MASSAGE THERAPY
☐ WET DIAMOND (Medical Use Only)
☐ MICRODERMABRASION

SECTION 1: MEDICAL INFORMATION

Absolute Contraindications

YES	NO	
☐	☐	Accutane or other similar medication
☐	☐	Autoimmune disease, HIV, lupus, hepatitis, scleroderma
☐	☐	Active infection in the treatment area
☐	☐	Melanoma or lesions suspected of malignancy
☐	☐	Active Sunburn
☐	☐	Pregnancy (medical-legal)
☐	☐	Breastfeeding (medical-legal, may increase skin sensitivity & likelihood of PIH
☐	☐	Epilepsy contraindicated for LED light therapy

Relative Contraindications

☐	☐	Anticoagulants therapy (use lower settings)
☐	☐	Very thin skin
☐	☐	Other Aesthetic Treatments: Botox: wait 5-7 days; Fillers: wait 7-10 days; Peels: wait 30 days
☐	☐	Laser Treatments: wait until lesions heal & swelling & redness is resolved

Other Concerns

☐	☐	Keloids: avoid direct contact
☐	☐	Rosacea, telangiectasia (use lower vacuum)
☐	☐	Unrealistic expectations

If you answered **YES** to any of the above questions, please explain:

_____
_____

Please list any known allergies:

_____

Specify your areas of concern (i.e. eyes, forehead, etc.) _____
_____
_____

SECTION 2: CLIENT CONSENT FORM
(Initial each acknowledgement line below)

1. I acknowledge that my skin might experience temporary irritation, tightness, or redness, which usually dissipates within 72 hours depending on skin sensitivity. _____(initial here)
2. 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. _____(initial here)
3. I have disclosed my history of allergies above and I acknowledge that if I am allergic to one or more of the ingredients in the products used, I may experience an allergic reaction. _____(initial here)
4. I hereby agree to have the treatment performed and agree to follow all pre and post treatment instructions. _____(initial here)
5. 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 in the treated areas for minimum 2 weeks pre and post treatment. _____(initial here)
6. 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 pre and post the treatment. _____(initial here)
7. I acknowledge that I have answered all questions truthfully and completely. _____(initial here)
8. I release Edge Systems, the _____ (Aesthetician/Doctor), management and staff of_____ (Clinic/Office) from any and all liability associated with any injuries and/or current orfuture conditions resulting from the skincare procedures or products. _____(initial here)
9. 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. _____(initial here)

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

Client Signature: _____ Date: _____

Operator Signature: _____Date: _____