

CLIENT CONSULTATION AND RELEASE FORM

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

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

- HYDRAFACIAL MICRODERMABRASION BLUE LED LIGHT THERAPY ULTRAMAX
 RED LED LIGHT THERAPY LYMPHATIC/MASSAGE THERAPY

GLY ____%, SAL ____% and GLY ____%. SAL ____% and GLY ____%. SAL ____%, PEELS TO BE USED

SECTION 1: MEDICAL INFORMATION

- Do any of the following conditions relate to you?

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Accutane or other similar medication
<input type="checkbox"/>	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease, HIV, lupus, hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Blood thinners – Heparin, Coumadin, Warfarin, etc.
<input type="checkbox"/>	<input type="checkbox"/>	Breast feeding, pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Cancer or post-cancer treatments
<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular problems
<input type="checkbox"/>	<input type="checkbox"/>	Cold sores or fever blisters without pre-medication
<input type="checkbox"/>	<input type="checkbox"/>	Cortisone or steroid injections
<input type="checkbox"/>	<input type="checkbox"/>	Cosmetic injections, fillers or implants, (i.e. Botox®, collagen)
<input type="checkbox"/>	<input type="checkbox"/>	Eczema, psoriasis
<input type="checkbox"/>	<input type="checkbox"/>	Enlarged or painful glands
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Facial waxing services w/in 7-14 days
<input type="checkbox"/>	<input type="checkbox"/>	Heart ailment
<input type="checkbox"/>	<input type="checkbox"/>	Hypertension/high blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Inflammatory conditions
<input type="checkbox"/>	<input type="checkbox"/>	Irregular, pigmented moles, warts or growths, unidentified facial growth or mark
<input type="checkbox"/>	<input type="checkbox"/>	Keloids, pigmented scars, icepick scars, new scar tissue
<input type="checkbox"/>	<input type="checkbox"/>	Laser procedures, chemical peels, dermabrasion, microdermabrasion
<input type="checkbox"/>	<input type="checkbox"/>	Light sensitive medication
<input type="checkbox"/>	<input type="checkbox"/>	Loose, thin, aged skin
<input type="checkbox"/>	<input type="checkbox"/>	Lymphatic disorder, inflammation of lymph vessels, lymphedema
<input type="checkbox"/>	<input type="checkbox"/>	Medication:
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker or metal implants
<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis, varicose veins
<input type="checkbox"/>	<input type="checkbox"/>	Recent accident or serious injury
<input type="checkbox"/>	<input type="checkbox"/>	Recent surgical or dental procedure
<input type="checkbox"/>	<input type="checkbox"/>	Rosacea, telanglectasia/couperose
<input type="checkbox"/>	<input type="checkbox"/>	Retin-A, Retinol
<input type="checkbox"/>	<input type="checkbox"/>	Skin abrasions or lesions
<input type="checkbox"/>	<input type="checkbox"/>	Stage III or IV acne
<input type="checkbox"/>	<input type="checkbox"/>	Skin-lightening or bleaching agent
<input type="checkbox"/>	<input type="checkbox"/>	Sunburn
<input type="checkbox"/>	<input type="checkbox"/>	Swollen or infected tonsils
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid conditions
<input type="checkbox"/>	<input type="checkbox"/>	Type I diabetic
<input type="checkbox"/>	<input type="checkbox"/>	Under medical care for an existing or suspected condition or disease
<input type="checkbox"/>	<input type="checkbox"/>	Viral infection, influenza
<input type="checkbox"/>	<input type="checkbox"/>	Other contraindication at discretion of skincare technician or medical practitioner:

- My interest in skincare treatment is primarily for (i.e. skin rejuvenation, acne, hyper-pigmentation, scarring, etc.) _____
- Specify your areas of concern (i.e. eyes, forehead, etc.) _____

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

1. I acknowledge that I have not used Accutane or any medication for the same purpose during the last 12 months. _____ *(initial here)*
2. I acknowledge that if I have ever had a cold sore 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. _____ *(initial here)*
3. 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. _____ *(initial here)*
4. I acknowledge that my skin might experience temporary irritation, tightness, redness or slight swelling which usually dissipates within 72 hours depending on skin sensitivity. _____ *(initial here)*
5. I acknowledge that if I fail to use a minimal sunscreen (SPF 15), I am more susceptible to sunburn, skin damage & hyperpigmentation. _____ *(initial here)*
6. I acknowledge that this treatment is strictly an elective cosmetic procedure and that no medical claims have been expressed or implied. _____ *(initial here)*
7. I acknowledge that I should avoid use of glycolic products for 2-4 weeks following the treatment. _____ *(initial here)*
8. I acknowledge that I should avoid use of Retin-A type products for a period of time recommended by my medical or skincare professional during and following the treatment. _____ *(initial here)*
9. I acknowledge that I am not pregnant/lactating. _____ *(initial here)*
10. I hereby agree to have the treatment performed and agree to follow all pre and post treatment instructions. _____ *(initial here)*
11. I acknowledge that I have answered all questions truthfully and completely. _____ *(initial here)*
12. I release the instructors, management and staff of Edge Systems Corporation and _____, from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products. _____ *(initial here)*
13. I consent to the use of my before, during and after facial procedure photographs for education, promotion or advertising purposes. _____ *(initial here)*
14. I acknowledge that this Edge Systems GlySal Acid Peel treatment is strictly an elective cosmetic procedure and that no medical claims have been expressed or implied. _____ *(initial here)*
15. I acknowledge that I should avoid use of aggressive exfoliations, waxing or products containing acids for 2-4 weeks following Edge Systems GlySal Acid Peel Series. _____ *(initial here)*
16. I release the instructors, management and staff of Edge Systems Corporation and _____, from any and all liability associated with any injuries and/or current or future conditions resulting from the GlySal Acid Peel procedures. _____ *(initial here)*

Client Signature: _____ Date: _____

Skincare Practitioner Signature: _____ Date: _____

HydraFacial MD®

GlySal MD Acid Peel Delivery System