General Medical Aesthetics Release Form / Hold Harmless

I hereby consent to and authorize **Mercedes Fletcher** to perform the following treatment:

_____

Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications of this treatment. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.

I have read and understand the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the practitioner immediately.

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies, prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the treatment and accept the risks. All my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold the technician (nor the establishment), 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. I also release **Mercedes Fletcher** of any liability that may arise from this procedure.

Client Name (Printed)

_____

Client Name (Signature)

_____Date_____

Health History Intake Form

Date: _____

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____

Age: _____

Phone #: (_____) _____ Email: _____

Known allergies and reactions:

_____

List current medications (topical & oral):

_____

Cancer		Eczema	
Diabetes		Immune Disorder	
Hysterectomy		Skin Disease/Disorder	
AIDS/HIV		Varicose	
Psoriasis		Veins/Phlebitis	
Spinal Injury		Pacemaker/Defibrillator	
Keloid Scarring		Thyroid Disorder	
Menopause		Blush/Redden Easily	
High/ Low Blood Pressure		Depression/Anxiety	
Claustrophobia		Bruise Easily	
Hormone Imbalance		Lupus	
Hepatitis A/B/C		Fibromyalgia	
Rosacea		Circulation Disorder	
Cold Sores		Metal Implants/ Pins	
Blood Clot Disorder		Heart Disease	

Please check any of the following that apply:

Other: _____

1. Do you smoke? Y / N

2. Do you wear contacts? Y / N

3. Do you follow a restricted diet? Y / N

Are you currently under the care of a physician or dermatologist? Y/ N If so, explain.

_____

Any surgeries within the last 6 months? Y / N If so, explain.

_____

Client Consent: I understand, have read and completed the questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin from treatments received. I am aware that it is my responsibility to inform the practitioner of my current medical or health conditions and to update this history. I understand that the services offered are not a substitute for medical care and any information provided by the practitioner is for educational purposes only and not diagnostically prescriptive in nature. I understand that the information herein is to aid the practitioner in giving better service and is completely confidential. The treatments I receive here are voluntary and I release **Mercedes Fletcher** from any liability and assume full responsibility thereof.

Client Signature _____Date: _____

Photographic Consent:
I consent to photographs being taken before, during and after each procedure. I agree to these photos being stored electronically in my case file and will be used only with my written consent for promotional purposes.

Client Signature: _____Date: _____