

CALISTA

Skin & Laser Center

CLIENT CONSULTATION AND RELEASE FORM

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

Name: _____ Phone: (____) _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

HYDRAFACIAL
 MICRODERMABRASION
 LYMPHATIC/MASSAGE THERAPY

SECTION 1: MEDICAL INFORMATION

Absolute Contraindications		
YES	NO	Medical Information
		Accutane or other similar medication (in the past year)
		Autoimmune disease, HIV, lupus, hepatitis, scleroderma
		Active infection in the treatment area
		Melanoma or lesions suspected of malignancy
		Active sunburn
		Pregnancy (medical-legal)
		Epilepsy contraindicated for LED light therapy
Relative Contraindications		
		Anticoagulants therapy (use lower settings)
		Very thin skin
		Other Aesthetic Treatments: Botox & Filler: wait 5-7 days; Aggressive 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)

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

Please list any known allergies:

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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)
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)
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)
4. I hereby agree to have the treatment performed and agree to follow all pre and post treatment instructions. _____(initial)
5. I acknowledge that I have answered all questions truthfully and completely. _____(initial)
6. I release Calista Skin & Laser, _____ (Technician/Doctor), management and staff of Calista Skin & Laser from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products. _____(initial)
7. 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)

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: _____