

# Health Rhythms Medi Spa & Tan

4250 E. Florida Ave., Hemet, CA 92544

## MICRODERMABRASION CLIENT RELEASE AND INFORMED CONSENT FORM

PLEASE READ THE FOLLOWING INFORMATION AND ACKNOWLEDGE THAT YOU UNDERSTAND  
AND ACCEPT ALL PROVISIONS BY SIGNING BELOW

I, \_\_\_\_\_, acknowledge and agree to hold Health Rhythms Medi-Spas & Tan, Inc. and any of its employees harmless against any and all liability and claims for any injuries or any other occurrence of events directly caused by active negligence of Health Rhythms Medi-Spas & Tan, Inc. or any of its employees.

Areas to be treated: \_\_\_\_\_

Number of treatments estimated: \_\_\_\_\_

- ❖ The nature and purpose of the treatment has been explained to me, and any questions I have regarding this procedure have been explained to my satisfaction. \_\_\_\_\_ (Initial)
- ❖ I understand that with any treatment certain risks are involved and that any complications or side effects from known or unknown causes could occur. I freely assume these risks. \_\_\_\_\_ (Initial)
- ❖ Possible side effects include, but are not limited to: mild redness, extreme redness, bruising, local swelling, stinging, tenderness, dry skin, flaking, lightening or darkening of the skin, infections, pimples, bumpy appearance, and cold sores. Most side effects are temporary and generally subside within 24-72 hours. \_\_\_\_\_ (Initial)
- ❖ If I am prone to herpetic outbreaks, I have been advised to see my physician about a prescription for Acyclovir, Zovirax, or to take supplement of L-Lysine, Beta-Carotene and Folic Acid daily. \_\_\_\_\_ (Initial)
- ❖ I have been advised to discontinue all AHA's Glycolic, Retin-A, Renova, or any exfoliating products for up to 72 hours post-procedure. I understand that I must use hydrating and soothing antioxidants for healing, and ice for swelling and inflammation reduction. Also, I understand there should be no sun or tanning bed exposure for 72 hours and the use of an SPF-30 at all times during treatment is advised. \_\_\_\_\_ (Initial)
- ❖ I have been advised to avoid collagen injections for up to 10-14 days before and up to 7 days after any microdermabrasion treatment. I agree to these restrictions. \_\_\_\_\_ (Initial)
- ❖ I agree to all safety precautions and home skin care program as recommended by my practitioner. \_\_\_\_\_ (Initial)
- ❖ I am over 18 years of age or I have parental consent co-signed below. \_\_\_\_\_ (Initial)
- ❖ I will call to inform my practitioner of any complications or concerns as soon as they occur. \_\_\_\_\_ (Initial)
- ❖ In the case of missed appointments we reserve the right to charge your account a fee of \$50.00 if you do not call in advance. \_\_\_\_\_ (Initial)

I have read the contents of this consent form carefully and agree to receive the treatments or series of treatments outlined above.

Signature: \_\_\_\_\_ Client #: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name of Client: \_\_\_\_\_

Technician/Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For visually handicapped or illiterate persons:** This release form has been read to the client in my presence.

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

I HEREBY GIVE MY PERMISSION as Parent [ ] Guardian [ ]

of \_\_\_\_\_ who is \_\_\_\_\_ years of age, to receive treatment at this facility. I have read and fully understand this *Client Release and Informed Consent Form* and hereby agree to accept all of the provisions.

Signature: \_\_\_\_\_ Client #: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name of Parent/Guardian: \_\_\_\_\_