

# Blush

## MEDICAL AESTHETICS

### WAXING CONSENT FORM

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

D.O.B: (MM/DD/YYYY) \_\_\_\_\_ Phone Number \_\_\_\_\_

Email \_\_\_\_\_

Are you a diabetic?

Yes

No

Are you pregnant?

Yes

No

Have you taken Accutane in the last year?

Yes

No

Are you using Retinoids?

Yes

No

Do you use tanning beds regularly?

Yes

No

Are you currently sunburnt?

Yes

No

Have you recently had a facial / chemical peel?

Yes

No

Do you have any allergies?

Yes

No

If yes, please list:

Current medications? Please list (if they may interfere with the service being provided)

Do you currently have, or have you ever had any of the following medical conditions that could compromise your skin?

AIDS / HIV

ECZEMA / PSORIASIS

COLD SORES / HERPES

HEPATITIS

CANCER

## VERICOSE VEINS

Please initial the following:

\_\_\_\_\_ CHANGING YOUR APPOINTMENT: A minimum of 24 hours' notice is required to reschedule or cancel a booked appointment without penalty.

\_\_\_\_\_ CANCELLATIONS / NO SHOWS: Repeated no shows, cancellations or late arrivals will be charged a 50% non-refundable deposit before they can re book. If you are more than 15 minutes late for your appointment, this may result in a shortened service or an appointment cancellation all together.

\_\_\_\_\_ SICKNESS OR FAMILY EMERGENCY: If you, or another person in your household, has an infectious or contagious illness, please contact us as soon as possible to reschedule your appointment for a later date. For your safety and that of staff and other clients, please do not come to your appointment sick. A one-time allowance of last-minute cancellation or reschedule will be permitted for sickness or family emergency. After that, the cancellation and no-show policy will be in effect. (50% DEPOSIT MUST BE MADE UP FRONT)

\_\_\_\_\_ ALL PRODUCTS FOR SALE ARE FINAL SALE. EXCHANGES ONLY. NO REFUNDS. NO STORE CREDITS.

I, \_\_\_\_\_, hereby acknowledge and understand that I am receiving aesthetic treatment(s) described as waxing at "Blush Medical Aesthetics". I give my voluntary and informed consent to receive the treatment(s) as listed. I understand that there may be physical contact involved in these treatments and I am not aware of any medical reasons that would preclude me from requesting or receiving treatment(s) of this nature.

I hereby agree to defend, indemnify, and save harmless "Blush Medical Aesthetics" and or it's principles, employees, or agents from any claims which might arise in relation to any allergic reaction and or any other potential liability which might arise from or in the context of the treatment(s) received at "Blush Medical Aesthetics". I accept any such liability as a voluntary assumption of risk and acknowledge that this is a condition precedent to receiving the treatment(s) as listed.

Before and after treatment advice/protocols have been discussed with me and that adherence to such advice / protocols is necessary for optimal treatment results and to avoid undesirable effects after treatment(s).

The treatment(s) as well as potential benefits and risks associated have been explained to me and meet my satisfaction.

I am satisfied that all my questions have been answered.

I freely consent to the treatment(s) as listed above.

First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Signature \_\_\_\_\_

Date (MM/DD/YYYY) \_\_\_\_\_

Service Provider: \_\_\_\_\_