



CONFIDENTIAL TREATMENT CONSENT

Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ - _____ - _____ (home) _____ - _____ - _____ (cell) _____ - _____ - _____ (work)
Email: _____ @ _____ .com

Circle your current level of stress: 1 2 3 4 5 6 7 8 9 10

Circle your normal level of stress: 1 2 3 4 5 6 7 8 9 10

How many ounces of water to you drink daily? _____ Do you take Supplements/Vitamins? _____

Do you Exercise? _____ If yes, how often: _____ Do you Tan (indoor or outdoor)? _____

How did you hear about us? _____

When out in the sun, do you? (circle one)

Always Burn (I) Usually Burn (II) Sometimes Burn (III) Rarely Burn (IV) Very Rarely Burn (V) Never Burn (VI)

Have you ever had a professional Facial Treatment before? Yes No If Yes, what type of treatment(s):

What are your skin (face and body) concerns? _____

Are you currently using sun protection? Yes No If yes, how often? _____

Circle how you feel about the overall quality of your skin: (bad) 1 2 3 4 5 6 7 8 9 10 (fantastic)

Your skin type is? (circle one) Normal Dry/Dehydrated Oily Acne/Acne Prone Combination Rosacea

In Order of Importance, Please Rank 1 (most important) to 5 (least important) improvements in the next 30 days:

____ Reduction of Fine Lines

____ Reduction of Brown Spots/Sun Damage

____ Reduction of Oil/Acne

____ Acne Scars Diminished

____ Reduction of Redness

SIGNATURE: _____ DATE: _____



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CLIENT INFORMATION	
Date	Home Phone
Name	Work Phone
Address	Cell
City/State/Zip	Email

TREATMENT (Select One)	SKIN CONDITION (Select all that apply)	
<input type="checkbox"/> Wrinkle Lift	<input type="checkbox"/> Lightening Lift	<input type="checkbox"/> Superficial Wrinkle, Fine Lines
<input type="checkbox"/> Acne Lift	<input type="checkbox"/> 4 Layer Facelift	<input type="checkbox"/> Rosacea
<input type="checkbox"/> Micro/Peel	<input type="checkbox"/> Organic Passion Peel	<input type="checkbox"/> Acne/Oily
<input type="checkbox"/> TCA Peel	<input type="checkbox"/> Perfection Lift	<input type="checkbox"/> Hyperpigmentation
		<input type="checkbox"/> Severe Photoaging
		<input type="checkbox"/> Dehydration
		<input type="checkbox"/> Acne Scars
		<input type="checkbox"/> Unbalanced

PRECAUTIONS (Please Read Carefully)

The Image Treatment you will receive is a clinical treatment designed to exfoliate or remove the outer layers of skin.

Your participation in your skin care treatments will determine the outcome. It is important that you strictly adhere to your at home care products that your esthetician has recommended.

No guarantee is expressed or implied as to the precise results, peeling times or discomfort.

Depending on the treatment, you may experience some temporary stinging or warm flushing. This will fade within 5 minutes. During the next few hours, you may experience some tightening of the skin, which may last several days.

For most clients, a light flaking begins within 48 hours. It is impossible to pre-determine how much peeling will occur. The shedding process usually subsides within 2-3 days.

PLEASE INITIAL (Please Read Carefully)

<input type="checkbox"/> I AM NOT PREGNANT. **	<input type="checkbox"/> I AGREE TO AVOID DIRECT SUN EXPOSURE FOR 48 HRS.
<input type="checkbox"/> I AM NOT ALLERGIC TO ASPIRIN.	<input type="checkbox"/> I AGREE TO NOTIFY MY ESTHETICIAN OF ANY CONCERNS.
<input type="checkbox"/> I DO NOT HAVE ACTIVE COLD SORES.	<input type="checkbox"/> I AGREE TO APPLY SUNSCREEN DAILY.
<input type="checkbox"/> I HAVE NOT TAKEN ACCUTANE IN THE PAST YEAR.	<input type="checkbox"/> I AGREE NOT TO WAX FOR 7 DAYS PRE/POST TREATMENT.
<input type="checkbox"/> I AGREE IT IS MANDATORY TO USE IMAGE POST PEEL KIT	<input type="checkbox"/> I AGREE NOT TO USE RETINOL PRODUCTS 5 DAYS PRE/POST
<input type="checkbox"/> I AGREE THERE MAY BE CRUSTING AND SHEDDING OF SKIN. (**EXCEPTION: 4 Layer Facelift & Passion Peel safe for pregnant women.)	<input type="checkbox"/> I AM UNDER THE SUPERVISION OF A PHYSICIAN AND HAVE DISCUSSED THE TREATMENT PLAN WITH MY PHYSICIAN.

CONSENT (Please Sign)

I hereby give my consent and authorization voluntarily and release ABOUT FACE from any claims, implied or stated that I have or may have in the future with this treatment, regardless of results.

I am stating that the treatment and precautions above have been explained to me in detail and that I fully understand.

CLIENT SIGNATURE: _____ **DATE:** _____

WITNESS: _____ **DATE:** _____