MICRODERMABRASION
CLIENT INTAKE FORM

APPOINTMENT DATE: _____ APPOINTMENT TIME: _____

NAME:	AGE:	GENDER:
ADDRESS:	ZIP:	STATE:
EMAIL:	PHONE:	

Opt-in for email list to receive information & offers: ☐ Yes ☐ No

How did you hear about us? ☐ Friends/Family ☐ Social Media Other: _____

Skin Type: ☐ Oily ☐ Dry ☐ Combination ☐ Sensitive ☐ Reactive

What concerns you most about the overall appearance of your skin? (check all that apply)

- ☐ Acne
- ☐ Dehydrated Skin
- ☐ Dull Complexion
- ☐ Acne Scarring
- ☐ Excessive Facial Hair
- ☐ Facial Veins
- ☐ Age Spots
- ☐ Fine Lines/Wrinkles
- ☐ Large Pores
- ☐ Melasma
- ☐ Redness
- ☐ Broken Blood Vessels
- ☐ Oily Skin
- ☐ Bumps On Arms
- ☐ Rough/Uneven Skin Texture
- ☐ Rosacea
- ☐ Cysts/Nodules
- ☐ Sun Damage
- ☐ PIH
- ☐ Blackheads
- ☐ Whiteheads
- ☐ Frequent Breakouts

Other: _____

How would you describe your stress level? ☐ Low ☐ Moderate ☐ High ☐ Severe

GENERAL HEALTH:

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain: _____

Any allergies? (Sulfa, food, iodine, medications, hay fever, latex) ☐ Yes ☐ No

If yes, please specify: _____

Are you currently taking any medications, herbs or vitamins? ☐ Yes ☐ No

If yes, please specify: _____

How many glasses of water do you consume daily? _____

When exposed to sun, do you: ☐ Burn Easily ☐ Tan Easily ☐ Never Burn ☐ Never Tan

What's your general health? _____

Are you prone to cold sores? ☐ Yes ☐ No If yes, date of last cold sore: _____

If yes, do you have a prescription for Valtrex or similar for prevention? ☐ Yes ☐ No

For women only: ☐ HRT ☐ Menopause ☐ Pregnant ☐ Birth Control Pills

Do any of the following apply to you? ☐ Smoker ☐ Wear Contacts

Please check if using any of the following:

- ☐ Hydroquinone
- ☐ Glycolic /Alpha Hydroxy Acid
- ☐ Retinoid (Vitamin A derivatives: Retin-A, Renova, Differin, Tazorac, Tretinon)
- ☐ Other: _____

Have you ever had any of the following?

- ☐ Botox Injections Date: _____
- ☐ Collegen Injections Date: _____
- ☐ Blepharoplasty (Eye Lift) Date: _____
- ☐ Rhytidectomy (Face Lift) Date: _____
- ☐ Restylane Injections Date: _____
- ☐ Laser Resurfacing Date: _____
- ☐ Rhinoplasty (Nose) Date: _____
- ☐ Skin Cancer Date: _____

Have you recently received any of the following?

- ☐ Face Treatment Date: _____
- ☐ Chemical Peel Date: _____
- ☐ Laser/IPL Date: _____
- ☐ Microneedling Date: _____
- ☐ Ultherapy Date: _____

Please check the skincare products you are currently using:

☐ Cleanser ☐ Eye Cream ☐ Scrub ☐ Serum ☐ Mask ☐ Toner
☐ Moisturizer ☐ Self Tanner ☐ Retinol ☐ Concealer

Other: _____

I have read the above information. I have accurately answered the questions above, including all known allergies, medications, or products I am currently ingesting or using topically. I give permission to my skin therapist to perform the ***Microdermabrasion treatment*** we have discussed and will hold him/her and his/her staff harmless from any liability that may result from this treatment. I understand the procedure and accept the risks. I do not hold the skin therapist, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this procedure, that may be affected by the treatment performed today.

_____	_____	_____
Client Name (Printed)	Client Signature	Date
_____	_____	_____
Skin Therapist Name	Skin Therapist Signature	Date

MICRODERMABRASION
CLIENT CONSENT FORM

PLEASE INITIAL: Although every precaution will be taken to ensure your safety and wellbeing before, during, and after the ***Microdermabrasion treatment***, please be aware of the following information and possible risks.

Initial Below:

____ I understand that microdermabrasion is an elective skin rejuvenation treatment intended to remove superficial surface layers of the skin to improve tone, texture, and clarity.

____ I have been informed of alternative treatments, which include: chemical peels, intense pulsed light (IPL), skin care products or no treatment at all.

____ I understand that the result of a one-time treatment is similar to a deep cleansing or polishing of the skin. I understand that in order to see significant results, these treatments need to be done in a series and in combination with using active ingredient skin care products.

____ I acknowledge that after my microdermabrasion procedure, treated areas may feel warm and appear sunburned; or my skin may experience a wind-burned sensation.

____ I understand that no specific guarantees can or have been made concerning the expected results.

____ I am satisfied with the information provided to me regarding microdermabrasion and agree to have the procedure performed on me.

____ I understand that compliance to my post-care instructions will greatly affect my final result. I acknowledge my obligation to follow the written and spoken instructions covering my pre and post-treatment skin care regimen.

____ I understand that although rare, certain risks or complications could occur; but are usually treatable and temporary, such as hyperpigmentation, hypo-pigmentation, and scarring. Following all post procedure instructions will help avoid these conditions.

____ I acknowledge that if I am prone to Herpes (cold sores, fever blisters) that I may need a prescription for an anti-viral (Valtrex) prior to having microdermabrasion. I understand that I need to avoid treatments during a breakout

____ I acknowledge that I have not used Accutane during the last 12 months.

____ I acknowledge that I have not had dermal fillers or other injectables in the treated area 10 days to 14 days in the past 10 – 14 days.

____ I acknowledge that I should avoid the use of alpha-hydroxy acids, beta hydroxy acids and Retinol products 1 week prior to and following treatment.

____ I have read and completed this consent form in its entirety, and have answered everything to the best of my ability.

I have read the contents of this consent form carefully, and I fully understand it. I have been given the opportunity for discussion pertaining to ***Microdermabrasion treatment*** and all my questions have been answered to my satisfaction. I hereby waive the establishment and any of its employees against any and all liability associated with this procedure. I have been adequately informed of the risks and benefits of this treatment and wish to proceed with the ***Microdermabrasion treatment.***

By signing below, I verify that I have read and understand the above statements and agree to them.

Client Name (Printed) _____ Client Signature _____ Date _____

WAIVER CONSENT FORM

ALLERGIC REACTIONS / SIDE EFFECTS

I, _____ am aware that LASH CHANCE BEAUTY, LLC is not liable for any allergic reaction and/or side effects I may develop during/after the service is performed, and there will be no refunds if an allergic reaction and/or side effect occurs..

Name Printed

Signature

Date

PHOTOGRAPH AND VIDEO RELEASE FORM

MICRODERMABRASION

PLEASE CHECK THE RELEVANT BOXE(S)

I understand that Lash Chance Beauty, LLC will take photos before and after the service is complete.

- ☐ I give permission for my photograph(s) to be used within the salon for display/ educational purposes.
- ☐ I give permission for my photograph(s) to be used within other printed publications.
- ☐ I give permission for my photograph(s) to be used on the salon's social media page and/or website.

Photographs taken on _____/_____/_____

I hearby grants permission to the rights of my image and video without payment or any other consideration. I understand that my image may be edited, copied, exhibit, published and waive the right to inspect or approve the finished product. I waive any right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be use in diverse educational settings within an unrestricted geographic area.

By signing this form I have read and understood the policy and agree to abide by the above conditions.

_____	_____	_____
Name Printed	**Signature**	**Date**

Lash Chance Beauty

POLICIES AND FEES

CANCELLATION AND NO SHOWS

Your appointment is very important. We understand that sometimes schedule adjustments are necessary. Therefore, we respectfully request at least 24 hours' notice prior to your scheduled appointment time for cancellations or rescheduling of appointments. Please notify us by e-mail if your cancellation is outside of our normal business hours or you're unable to reach us by phone at 631-449-3972.

ANY APPOINTMENTS CANCELLED/RESCHEDULED OR CHANGED WITHOUT 24 HOURS NOTICE WILL RESULT IN A CHARGE EQUAL TO 50% OF THE RESERVED SERVICE AMOUNT. ALL "NO SHOWS" WILL BE CHARGED 100% OF THE RESERVED SERVICE AMOUNT.

LATE ARRIVALS

We understand that sometimes being late is out of control but please keep in mind that showing up late will affect the time of your service. Our client's time is value and so is ours, we try our best to accommodate late arrivals by performing the most complete treatment possible in the time remaining. Unfortunately arriving too late to perform a service will result in cancellation and the associated cancelled fee.

We recognize the time of our clients and artist is valuable and have implemented this policy for this reason. When you miss an appointment with us, we not only lose your business but also the potential business of other clients who could have scheduled an appointment for the same time.

REFUNDS AND CLIENT'S SATISFACTION

Due to the nature of our service there are no refunds on any services. Please contact us within 72 hours of our service with any problems and/or concerns you have regarding your service. We feel that every client deserves the highest level of satisfaction. Should you not be satisfied please let us know immediately and we will discuss a solution.

Please remember that it is your responsibility to remember your appointment dates and times in order to prevent any missed appointments which result in a cancellation fee. Not receiving an electronic notification of your appointments from us is not sufficient reason to miss an appointment if the original confirmation notification was received timely.

By signing this form I have read and understood the policy and agree to abide by the above conditions.

Name Printed	Signature	Date