CLIENT AGREEMENT

Facial & Body Sculpting

Please relax, smile and complete all questions.
We are happy you are here.

Date: ______ [redacted]: ______
Name: ______ Address: ______
City: ______ State: ______ Zip Code: ______
Home Phone: ______ Fax: ______ Business Phone: ______ Fax: ______
Cell Phone: ______ Email: ______
Birthdate: ______ Age: ______ Sex: ☐ M ☐ F
Employer: ______
Address: ______
City: ______ State: ______ Zip Code: ______
Check One: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated No. of Children: ______
Name of Emergency Contact: ______ Phone No.: ______
Spouse's Name: ______
Whom may we thank for referring you? ______
How did you hear about Beautiful Image Facial & Body Sculpting™? ______

Please describe your skin care program – be specific with products and frequency of use: ______

Have you ever had a professional facial? ☐ No ☐ Yes If Yes, How often? ______
Do you have sensitive skin? ☐ No ☐ Yes If Yes, please describe: ______

Have you had any of the following procedures, and if so when?

☐ Chemical Peel ______
☐ Skin Resurfacing ______
☐ IPL ______
☐ Microdermabrasion ______
☐ Botox / Injectable Filler ______
☐ Surgery ______

Lifestyle choices can significantly improve or slow the results of this procedure. The following information will enable us to best customize a sculpting program for you. Please answer as honestly as possible.

YES	NO	(Age 5 to present)	Patient's Comments if Yes
○	○	Did/Do you use Tobacco? (list type and amount)	
○	○	Did/Do you intake alcohol? (type and amount per week)	
○	○	Salt Intake? (Add to food? – (seldom/frequently)	
○	○	Caffeine Intake? (type and amount per day)	
		How many hours of sleep do you get per night?	
		How many 8 oz glasses of water do you drink per day?	
○	○	Have you lost or gained any significant weight in the last twelve months? If so, how much?	
○	○	Are you on a Carb restricting Diet? If so how long?	
		What is your diet consist of? (Do you eat healthy foods?)	
○	○	Do you regularly exercise, and if so do you use weights, cardio, or both?	

Patient's Signature: ______ Date: ______

Certain conditions may require ...
and if so how long or what date was it treated?

YES	NO	Medical Condition – Please list type	Patient's Comments if Yes
O	O	Epilepsy?	
O	O	Pacemaker/Pacemaker Leads?	
O	O	Multiple Sclerosis?	
O	O	Heart Condition?	
O	O	Muscular Condition	
O	O	Pregnant (Due Date?)	
O	O	Metal IUD?	
O	O	Collagen Injections?	
O	O	Botox Injections?	
O	O	Cancer (type and how long?)	
O	O	Skin Disorders or Skin Allergies?	
O	O	Inflammation, infection or disease of Skin?	
O	O	Recent scar tissue?	
O	O	Facial metal implants?	
O	O	Lack of normal skin sensation?	
O	O	Any circulatory problems?	
O	O	Previous cosmetic surgery or procedures?	
O	O	Do you wear contacts?	

If you checked yes to any of the conditions listed above, please describe in detail: ______

Please list any prescription medications or nutritional supplements that you are currently taking: ______

What do you want to accomplish with Beautiful Image Facial & Body Sculpting™? ______

Client Consent and Authorization

INFORMED CONSENT: I hereby authorize the administration of a skin rejuvenation procedure using the non-surgical Beautiful Image Facial and Body Sculpting machine. I understand Facial and Body Sculpting involves the use of micro currents through the skin.

The nature and purpose of the treatment has been explained to me and any questions I have regarding the treatment have been explained to my satisfaction.

Photographs: I give permission for my photographs to be used to help document my treatment course.
________ By initialing here I authorize the use of my before and after photos for marketing and understand I will receive a free gift if they are used.

No guarantee, warranty or assurance as been made to me as to the results that may be obtained. I am aware that multiple treatments are necessary for desired results. Most patients require a number of treatments over several months with gradual results occurring over this time. No refunds will be given for treatments received. I understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment.

I release ________________ and his office staff and technicians from liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, and successors.

My signature below acknowledges that I have had an opportunity to view and/or receive a copy of the Provider's Notice of Privacy Practice.

Patient's Signature: ______________________ Date: ______________

Endermologie By Debbie Client Consent and Authorization

INFORMED CONSENT: I hereby authorize the administration of a skin rejuvenation procedure. I understand Facial and Body Sculpting involves the use of micro current through the skin.

The nature and purpose of the treatment has been explained to me and any questions I have regarding the treatment have been explained to my satisfaction.

PHOTOGRAPHS: I give permission for my photographs to be used to help document my treatment course.
____________By initialing here I authorize the use of my before and after photos for marketing and understand I will receive a free gift if they are used.

No guarantee, warranty or assurance as been made to me as to the results that may be obtained. I am aware that multiple treatments are necessary for desired results. Most patients require a number of treatments over several months with gradual results occurring over this time. NO REFUNDS WILL BE GIVEN FOR TREATMENTS RECEIVED. NO REFUNDS WILL BE GIVEN ONCE A PACKAGE HAS BEEN STARTED. I understand and agree that all services rendered to me are charged directly to to me and I am personally responsible for payment.

I release Debra McCaslin and her office staff and technicians from liability associated with this procedure. I certify that I am competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, and successors.

My signature below acknowledges that I have had an opportunity to view and/or receive a copy of the Provider's Notice of Privacy Practice.

PATIENT'S SIGNATURE: ______________________DATE__________________

APPOINTMENT POLICY FOR ENDERMOLOGIE, FACE LIFT, AND ALL OTHER ANTI-AGING SERVICES BY DEBBIE

In order to create a positive experience for all, I understand that some of our clients have time limitations, and as such, I do my best to accommodate everyone's treatment schedule by running on time.

In this regard, as a courtesy to others, it is very important that **you** arrive **on time** for your scheduled appointment.

If you do arrive late for your appointment and someone is scheduled right after you (which is normally the case), in fairness to the next client, your appointment will be cut short by the amount of time I need to start the next person on time and the regular charge for your session will apply.

Due to the fact that my schedule is extremely busy and at times there is a waiting list for people trying to get scheduled, I require a 24 hr. notice if you are going to cancel an appointment so that I can find someone else to fill your appointment time. Without that notice, I am losing my income and you are preventing someone else from being able to receive treatment that they could have otherwise gotten. As such by your signature below you recognize and agree to the fact that without a 24 hr. notice, except in an emergency situation, you will be charged for your appointment.

Thank you for your cooperation and understanding in this matter.

Sincerely,

Debbie McCaslin

Client's Name (Printed)______________________________

Client's Signature__________________________________

Date___________________