

Date: _____

Name: _____

Date of Birth: _____

Please initial all

_____ I hereby allow the staff at this Medi-Spa to provide me with a BLU-U treatment as explained in my consultation.

_____ I understand that the BLU-U Light emits a special frequency that may destroys acne causing bacteria.

_____ I understand that eye protection is important and that I would be required to wear eye protection at all times during my treatment.

_____ I further understand that a series of at least 10 treatments which consists of either 15 minutes twice a week or alternatively 30 minutes once a week consecutively would be required to constitute a treatment course.

_____ I understand that a cleansing of either a Microdermabrasion or clinical peel may be done before the BLU-U treatment.

_____ I understand that statistically there is a 60% chance of reduction of acne with this method of treatment should I complete the recommended treatment regime designed for me.

_____ I understand that medicine is not an exact science and that results may vary from person to person.

_____ I understand that should my results be unsatisfactory after my course of treatment, Dr. Van Aardt may advise a different course of treatment.

_____ For the purposes of accurate record keeping in connection with the care and treatment which I am receiving and will subsequently receive from this clinic, I the undersigned, consent to have this clinic's staff take before, during and after treatment close-up photographs of the involved area(s) and the anatomical region surrounding the involved area(s). These photographs shall be used for medical records and shall be treated with the same confidentiality as the remainder of my record at this clinic.

_____ I hereby grant my permission that should my result be exceptional that I will allow my photographs to be discreetly used as promotion material for the BLU-U treatment.

_____ I understand that payment of this treatment is non-refundable and that I will not hold anyone at this Medi-Spa responsible if this course of treatment is not to my satisfaction.

_____ I hereby declare that I have read the above information and upon signing this I agree with all of the above mentioned information.

Client Print Name_____
Date_____
Signature_____
Witness