Dr. R. van Aardt
Cosmetic Medicine

SPA SERVICES CONSENT

Name: _____ Date of Birth: _____

Contact Tel # (Cell): _____-_____-_____ (W): _____-_____-_____ (H): _____-_____-_____

Email: _____ Consent to use: __Y __N

Address:

Primary Skin Concerns: _____

Have you received any Spa or Clinical skin care treatments in the past? __Y __N
Have you received any Medical Aesthetic treatments in the past? __Y __N
If YES please list:

Do you have any allergies: __Y __N List: _____

Are you using or have used any of the following in the last six months:
__ AHA's or BHA's __ Accutane __ Retin A __ Retinol __ Tanning Beds __ Self Tanner
__ Body/Face Wax
__ Topical Meds List:

Please list all skin care products you are currently using and how often do you use them?
Facial Cleanser: ___am / ___ pm Toner: ___am / ___ pm Moisturizer: ___am / ___ pm
SPF: ___ every day / ___ per occasion Foundation: ___ daily Concealer: ___ daily
Exfoliate : ___ every day / ___ per week Masks: ___ every day / ___ per week

Please initial and sign below:

_____ **WAXING:** I voluntarily request that the Licensed Service Provider perform a waxing procedure. Waxing may cause redness, bruising, and photo-sensitivity for up to 48 hours. Breakouts may occur. Allergic reactions are less common. The use of Accutane or vitamin A derivative should be discontinued 6-12 months before waxing. Waxing should not be performed if you had a Botox treatment 72 hour prior, a chemical peel or Microdermabrasion treatment within the past 7-10 days and tanning should not be done 24 hours before waxing.

____ **TINTING OF LASHES / BROWS:** I voluntarily request that the Licensed Service Provider perform a tinting procedure. Brow and lash tinting can be done every 4-6 weeks depending on life style.

_____ **MANICURE:** I voluntarily request that the Licensed Service Provider perform a manicure procedure. This cosmetic procedure is a treatment of the hands including shaping, trimming, cleaning and polish of the fingernails.

_____ **PEDICURE:** I voluntarily request that the Licensed Service Provider perform a pedicure procedure. This cosmetic procedure is intended to treat your feet with a foot soak, trimming and shaping of the toenails, the cuticles trimmed and the calluses pumiced and finally the toenails painted. I acknowledge that I have informed my provider of any medical condition for example: Diabetes.

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

_____ I acknowledge that I will inform the Service Provider of any changes in symptoms, medications, diagnoses by other facility and if there is a chance of pregnancy at any time during my care.

By signing below I acknowledge that all my questions regarding procedures have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release the Service Provider at the Truro Medi-Spa from all liabilities associated with the above indicated procedure and hereby consent to the treatments initialled above.

Print Name of Client	Signature of Client	Date
Print name of Service Provider	Signature of Service Provider	Date