CLIENT RECORD BioRePeelCl3 Treatment

BioRePeelCl3
BIPHASIC TECHNOLOGY

Name _____

DOB _____

Address _____

_____

Phone _____

Email _____

RECOMMENDED

For specific targeted problems: 4-6 treatments, every 7-12 days.
Skin maintenance: After a course of 6 – wait 3 months.

During the treatment, as a result of the application of the product, you may experience a warm, tingling sensation on the skin. At all times, your therapist will be monitoring your treatment.

Over the following days after treatment, the area will feel tight and dry and a light shedding of the skin in particular areas can occur. It is important the aftercare is adhered to. No precise guarantees can be given about the result that can be obtained with this treatment and in particular on the duration of the effectiveness of the same, due to different factors can vary the therapeutic efficacy of the treatment.

POST TREATMENT AFTERCARE ADVICE

- No makeup for 24hrs
- No sunbeds / sunbathing / saunas / exercise / Swimming etc for24hrs
- Avoid rubbing or harsh exfoliants during course of treatments
- Avoid sun exposure & always use recommended SPF 50 minimum
- Do not use skincare with AHA / BHA for 7 days after
- Do not use Retinol products for 7 days
- Avoid electrolysis, waxing, bleaching for 36 hours
- Avoid any other invasive treatments for up to 2 weeks post treatment

PLEASE READ AND SIGN THAT YOU UNDERSTAND EACH STATEMENT

◯ I understand the aftercare protocols involved with this treatment.

◯ I understand that my skin will follow a process that continues for approx. 5 days after treatment. I may experience redness, dryness, tightness & some peeling post treatment.

◯ I have not used any products containing Retinoids for 3 days prior to treatment.

◯ Clients receive noticeable, satisfactory to above average results with a series of treatments and a commitment to a daily skin care regime. However, the outcome cannot be guaranteed as maximum results are dependent on age, cumulative sun exposure, health, lifestyle, genetic traits, general skin condition, and willingness to follow recommended protocols

Sign _____

Date _____

MEDICAL HISTORY (TO BE COMPLETED BY THE CLIENT)

If you suffer from any of the medical conditions listed below, it is your responsibility to notify your therapist / clinician, who can take the necessary precautions to ensure you, the client, is suitable to receive BioRePeel treatment and avoid any risks to your skin & health.

Please answer YES or NO to the following questions. These details will be discussed further if relevant to the treatment. If there is doubt, this can delay your treatment until further investigation.

	Y	N
Are you currently taking any medication? If YES please list:	○	○
_____		
Any allergies to any products? – In particular acids found in peels?	○	○
Any known allergy to Salicylic – Asprin?	○	○
Do you have at time of treatment any bacterial, fungal or viral infections? i.e.- Herpes / Impetigo	○	○
Do you have or suffer from active/sever eczema/ dermatitis/psoriasis (can have the treatment but unable to work on that area)? Autoimmune disorders?	○	○
Do you have hypersensitive skin?	○	○
Have you used Roaccutane or similar product in past 12 months?	○	○
Do you have any broken skin / sun burn?	○	○
Do you have any history of skin cancer?	○	○
Do you suffer from heart problems?	○	○
Do you have Epilepsy?	○	○
Are you undergoing Chemotherapy/radiation?	○	○
Do you suffer or have Keloid scarring?	○	○
Do you have or suffered from Hypo-pigmentation?	○	○
Have you had any medication or treatment that would result in Photosensation? (Anti-biotics etc)	○	○
Are you currently pregnant or breast feeding?	○	○

CONSENT

I hereby consent to receiving the 'BioRePeel' treatment. I will notify my Therapist / Clinician should there be any changes to my health or medication during the course of my treatments. My Therapist / Clinician has explained the above terms and conditions of the treatment, the importance of following the after care and I have fully understood them. I hereby give my written consent my Therapist / Clinician who is fully trained and insured to carry out the treatment of my choice as requested by me on this Client Record Consent Form.

Sign _____

Date _____

Print Name _____

Therapist Signature / Clinician Signature

_____

FOR OFFICE USE ONLY

BioRePeelCl3 FND 35%: _____

BODY 50% _____ BATCH: _____

Exp date: _____