ZK Skin Essentials

TAMA Waiver of Liability

Date: _____

Name: _____

DOB: _____ Age: _____

Address: _____

Phone # _____

Email: _____

Physician name and contact: _____

_____

Emergency name, contact and relationship: _____

_____

It is possible that you may suffer a physical injury, illness or adverse reaction as a result of undergoing the treatment and therapy offered by Žavinta Kalvinskaite. In the event that you have any adverse reaction to the administration of the treatment (or use of the Tama devices) administered in order to improve the tone and physical appearance of then skin and supporting tissue, be sure to immediately seek a physician for treatment or appropriate referral the treatment.

People with a current cancer diagnosis, have an implanted or other electrical stimulatory device, a history of seizures, epilepsy, or who are pregnant should not undergo the treatment and therapy offered by Tama devices, unless prescribed by a physician.

TAMA Devices

When activated, the Tama device will deliver a low current electrical stimulation, in combination with the application of a topical water, gel or lotion, and produces varying levels of electrical simulation, energy and intensity. The treatment and therapy offered by TAMA devices is not designed or intended to treat, cure, prevent or diagnose any disease, alignment or medical condition. No claims offered in relation to the therapy have been evaluated by the FDA. This information is not to be substitute for advice from your physician or health care professional.

Device Output/ Energy Levels/ Skin Response

The device applies an electrical stimulation measured between zero and 800 microamps.
Skin irritation or redness are possible and may be associated with the use of an electronic muscle stimulator. A doctor should be consulted before using any electronic muscle stimulator, in case you have

an undergoing medical condition, which the electronic muscle stimulator could aggravate. Always seek your doctor's opinion before engaging in a y new procedure.

Sensitive Medications or Skin Conditions

Certain medications, cosmetics or skin conditions may produce a greater sensitivity to the procedure. It is not recommended to undergo therapy if you have been diagnosed with physical condition affecting the skin. As for medications or cosmetics, typically, these products feature a warning label to notify you of potential adverse effects. Please consult a physician prior to therapy if you are using any such products or medications or have a history of skin problems or believe yourself ti be sensitive.

Waiver & Release of Liability

I expressly acknowledge that my use of the therapy is undertaken at me sole risk. Any change in physical activity or routine are done so voluntarily with the complete understanding that I am responsible for all actions and assume all risks of injury, illness, disease or death.

This waiver and release of liability includes, without limitations, all injuries that may occur as a result of (a) use of equipment or products applied topically in conjunction with the equipment, (b) the sudden and unforeseen malfunction of the equipment, (c) slipping or falling on the premises, including adjacent sidewalks, parking lots, etc.

I acknowledge that I have carefully read this waiver and product support materials and that I fully understand that this is a release of liability. I expressly agree to release and discharge the business, and all its affiliates, agents, employees, representatives, successors, or assigns, from any and all claims or causes of action and I voluntarily give up or waive any right that I may have to bring a legal action against the business for personal injury or property damage. To the extend that the statute or case law does not prohibit releases for negligence, this release is also for negligence on the part of the business, its employees and agents. F any portion of this release from liability shall be deemed by a court of competent jurisdiction to be invalid, then the remainder of the release from liability shall remain in full force and the offending provision(s) severed here form. This release supersedes all other signed release forms and shall be considered retroactive to the date of equipment usage. By signing this release I acknowledge that I understand its content and that this release cannot be modified orally.

Client Name Printed _____

Client Signature _____

Date of signature _____

Witness _____

Date of signature _____

Confident Medical History

Contraindications

- Have you ever been diagnosed with cancer? Yes No
- If yes, are you in remission? Yes No

If Yes, please request an authorization to treat from your physician and provide a copy prior to beginning the treatment.

If No, a current cancer diagnosis is a contraindication and we cannot proceed with TAMA therapy.

- Are you pregnant or planning to get pregnant? Yes No

If Yes, a pregnancy is a contraindication and we cannot proceed with TAMA therapy.

- Do you have a pacemaker/ Defibrillator? Yes No

If Yes, Pacemaker and Defibrillator are a contraindication and we cannot proceed with TAMA therapy.

- Do you have any electrical/ magnetic medical implants? Yes No

Shunt Hearing Aid Drug Delivery System Other

Explain: _____

- Are you able to remove/turn off your implant for the treatment? Yes No

If No, this is a contraindication and we cannot proceed with TAMA therapy.

- Do you have any history of seizures or epilepsy? Yes No

If Yes, this is a contraindication and we cannot proceed with TAMA therapy.

Treatment Considerations

- Have you had Botox, Kybella or filler injections? Yes No

If Yes, when? _____

- Do you have cardiac or circulatory problems? Yes No
- Do you bruise easily? Yes No
- Do you have high blood pressure? Yes No
- Do you have diabetes? Yes No
- Do you suffer form arthritis? Yes No
- Are you wearing contact lenses? Yes No
- Are you wearing dentures? Yes No
- Have you had any teeth removed? Yes No
- Do you have frequent headaches? Yes No
- Do you suffer form TMJD? Yes No
- Do you clench or grind your teeth? Yes No
- Do you have varicose veins? Yes No
- Have you ever had surgery? When? _____
- Do you have autoimmune disorder? Yes No
- Have you had Shingles? When? Yes No _____

I certify that I am not HIV positive, and don't have AIDS or Hepatitis C
(Initials please) _____

- Do you have any contagious diseases? Yes No
- Do you have osteoporosis? Yes No
- Have you been in an accident or suffered any injuries in the past two years?
  Yes No
- List current medications: _____

_____

_____

_____

_____

- List any allergies: _____

_____

_____

_____

- Do you have any other medical conditions that we should know about?
  Yes No

If Yes, please specify _____

_____

_____

_____

Diet

- How many times per week do you consume: Processed/fried food _____

Broiled/grilled foods _____ Baked goods _____ Meat _____ Fruits _____ Vegetables ____ Fish oil supplements ____ Vitamins ____ (Please specify): _____

_____

Other Supplements ____ (Please Specify) : _____

_____

- Do you follow a restricted diet? (Please Specify): _____

_____

- How many days per week do you consume: Caffeine _____ How mush x day _____

Alcohol x day _____ x week _____ Soft/diet drinks x day _____ x week _____

How much water daily? _____ (ounces or cups)

Activity

-Do you follow a regular exercise program? Yes No

Please specify exercise type and frequency _____

_____

-How quickly does your body respond to exercise? _____

-Are your leisure activities: Sedentary Active A balance of rest and activity

Stress

-Do you smoke? Yes No (how much and how often) _____

-What is our current stress level? High Medium Low

-Do you experience problems sleeping? Yes No (specify) _____

_____

-How many hours do you typically sleep each night? _____

Sun

-Have you been exposed to the sun or used a tanning bed in the last 72 hours?

Yes No

-How frequently are you exposed to the sun or use a tanning bed?

Never Frequently Regularly

-How many sunburns have you had before age 21? _____ after 21 _____

-Does your job or leisure require you to work outdoors or drive often?

Yes No

Pain

-Do you suffer from back pain? (Please specify) _____

_____

-Do you have tension or soreness in a specific area? (Please specify) _____

_____

_____

Goals

-Do you have an an event coming up you are preparing for? Yes No When? _____

-On a scale of 1-10, how motivated are you to reach a treatment goal by a specific event/date? (Please circle)

I'm just looking for a nice facial I want to see results

1 2 3 4 5 6 7 8 9 10

-On a scale of 1-10, how concerned are you about seeing change in your skin? (Please circle)

Not concerned Very concerned

1 2 3 4 5 6 7 8 9 10

-On a scale of 1-10, how willing are you to modify current habits, activities, and/or regimens in order to support and/or enhance your skin transformation? (Please circle)

Not willing Very willing

1 2 3 4 5 6 7 8 9 10

-Does your schedule allow for regular treatments? Yes No

____ I acknowledge that results will be individual and unique to me, and that my medical history and lifestyle may effect my results.

____ I acknowledge that best results will be a result of following the treatment schedule and home care plan as outlined by a professional affiliate.

____ I understand that the use of Botox, Juvederm, Restylane, and other injectable must be disclosed prior to treatment.

____ I understand that reactions are rare, but may include nausea, dizziness, weakness, and possible skin reactions including redness and/or other irritations.

____ I understand that some clients report slight tingling sensations, flashing of the optic nerve, and/or metallic taste in the mouth during the procedure.

____ I understand that while goal of the treatment is to improve the vitality of the skin, no specific guarantees of the result can or have been made.

____ I understand that it is imperative to me health that I disclose all of the information requested in the Client Profile/Health History.

____ I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.

____ I understand that additional conditions could occur or be discovered during the procedure which could affect my ability to tolerate the procedure.

____ I consent to "before and after" photographs for the purpose of documentation, potential advertising and promotional purposes.

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. **I understand that withholding information or providing misinformation may result in contraindications and/or adverse skin reactions from treatments and/or products received.** I am aware that it is my responsibility to inform the esthetician, skin care therapist of my current medical or health conditions and to update this history when necessary. **The treatments I receive here are voluntary and I release this institution and skin care professional from liability and assume full responsibility thereof.**

Client Name Printed_____

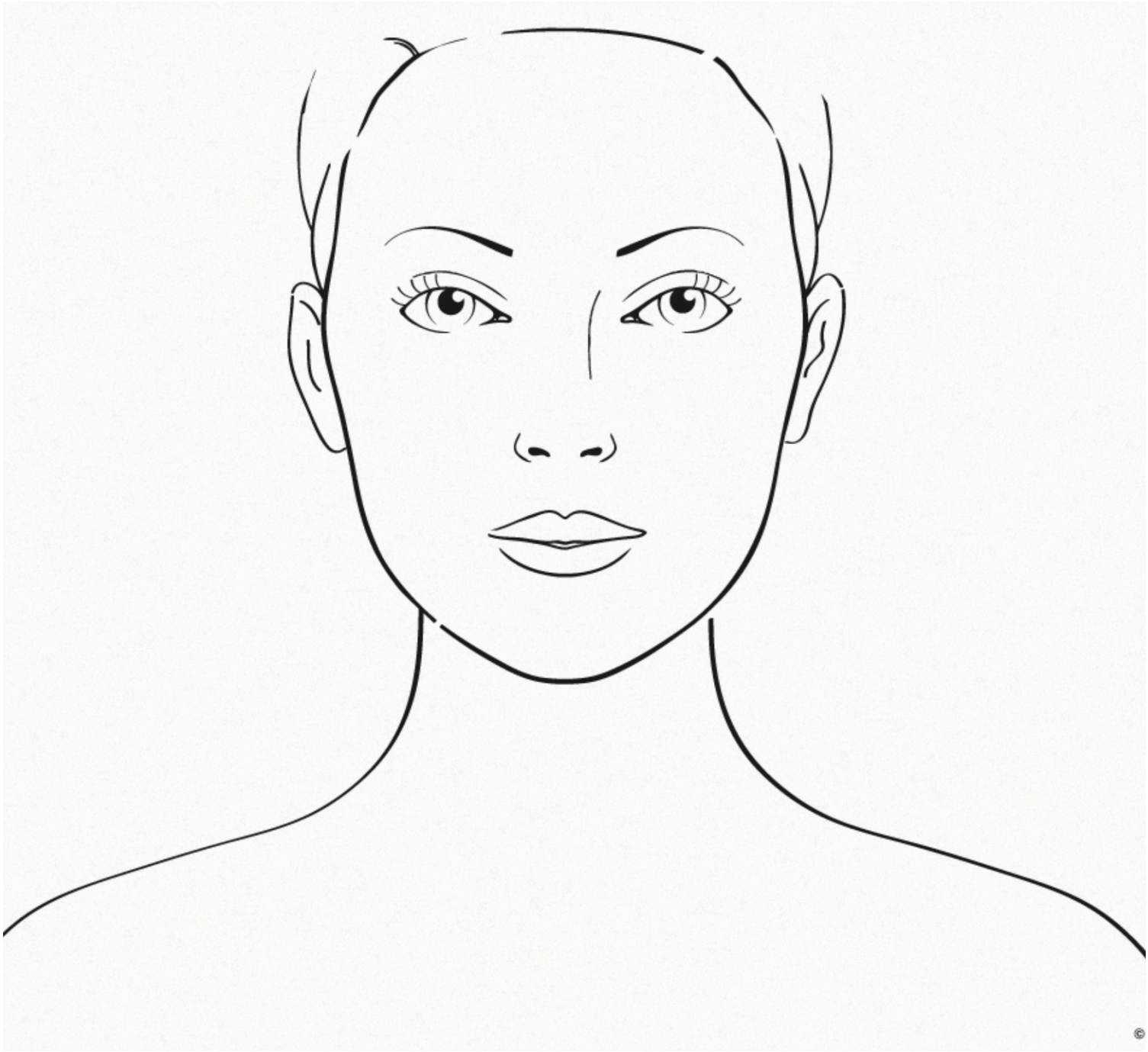
Client Signature _____

Date of Signature _____

Ares of Concern

Use the model to illustrate the areas you would like to see improvement

I- lines/wrinkle 0- acne/lesions x- redness v- sagging



Example: