Holistic Facelift Massage - Consent and Release Form

About Buccal Massage

Buccal massage focuses on the muscles of facial expression and can be performed intra-oral (inside the mouth) or outside of the mouth and cheeks. Intraoral work is performed with gloves, observing Universal Precautions. The Holistic Facelift also includes gentle Lymphatic drainage to reduce fluid retention in the face, scalp, and neck, along with Myofascial Release which involves a slow deep pressure to help relax and retrain the muscles. This service may include the use of cupping or gua sha. Some of the benefits of this service can include: reduced pain in the face, neck, and head, reduction in fluid retention, decreased appearance of lines, increase in facial symmetry, improved circulation, and a lifted-look.

Contraindications

- Pregnancy
- Acute Dental Issues, Recent Dental Work or Surgical Procedures of the Face, Neck or Scalp
- Uncontrolled Acne, Cold Sores, or Open Lesions, or Injuries to the Face, Neck or Scalp
- Recent Laser Resurfacing, Hair Removal, Deep Exfoliation within 4 weeks
- Botox, Fillers, or Other Injectibles, Tattoos/Microblading/Permanent Cosmetics within 4 weeks
- Uncontrolled Thyroid or Lymphatic Issues
- Epilepsy
- Use of Bloodthinners
- Current Cancer Treatment

Additional Considerations

Following your service you may experience temporary swelling, redness, soreness, mild bruising. Results are dependent on many factors including age, lifestyle, genetics, skin condition, health, client follow-through with recommendations, and are not guaranteed.

Please indicate if you wear any of the following:

☐ Contact Lenses	☐ Lash Extensions	☐ Hearing Aids
☐ Dentures, Braces, Oral Appliances	☐ Wig/Hair Extensions	☐ Other _____ _____

Current Beauty Routine (brand):

☐ SPF	☐ Cleanser _____	☐ Toner _____	☐ Moisturizer _____	☐ Other _____

Please indicate the conditions you hope to improve with Buccal Massage/Holistic Facelift

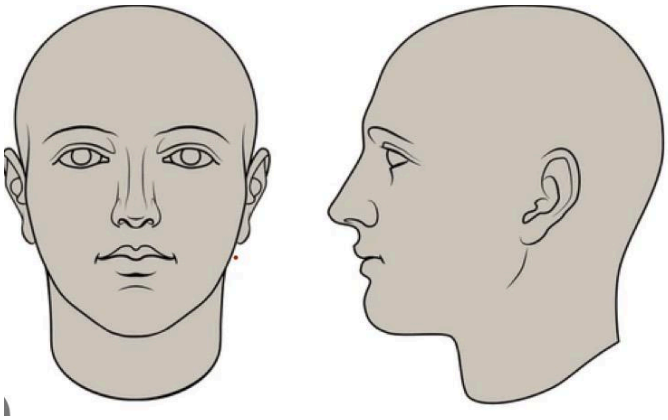
Wrinkles (specify where)_____ _____	Sagging Skin	Undereye Bags
Nasolabial Fold	Dull Complexion	Swollen Eyelids
Puffy/Swollen Face or Neck	Dark Circles or Wrinkles Around Eyes	Other_____

What are your Goals/Expectations for this treatment?

_____
_____
_____
_____

Describe any Concerns you have about your face or skin.

_____
_____
_____
_____



Mark the areas you wish to improve

Please Read and Initial Each Item Below

_____Information about buccal massage, potential benefits, effects, risks, and possible alternative therapies have been explained to me and I understand this information.

_____My therapist has informed me of the contraindications of buccal massage, and I have provided my therapist with an accurate and complete medical history to rule out any contraindications to receiving this treatment.

_____I have no contraindications for buccal massage and am not currently experiencing any symptoms or complications listed above or on the Health History form.

_____I have been given an opportunity to ask questions about buccal massage and have had my questions answered to my satisfaction.

_____I consent to photographic and/or video documentation of my progress. All photos/videos are property of New Moon Energy & Massage Therapy LLC and may be used for educational or marketing purposes, however, I will not be identifiable.

_____I wish to receive this treatment and agree to communicate to my therapist any physical discomfort experienced during the session.

_____My consent is informed and voluntary and I understand that I may withdraw my consent at any time except for actions already taken. I understand I may pause or discontinue the session at any time by signaling my therapist.

_____I release the massage therapist and New Moon Energy & Massage Therapy LLC from all liability for any harm that may unintentionally result from this treatment.

_____I further understand that massage is not a substitute for a medical examination or treatment, and that I should see a physician or other qualified health specialist for any mental or physical ailment of which I am aware. I understand that massage therapists do not diagnose illness or disease, and nothing said during the treatment should be construed as such.

By signing this form I agree with the statements above and give my consent to proceed with Buccal Massage/Holistic Facelift.

Client Name (Please Print)_____

Client Signature_____Today's Date_____