OSMOSIS TREATMENT CONSENT

CLIENT NAME: _____ **DATE:** _____

PLEASE INITIAL:

_____ I agree that the nature and purpose of the treatment has been explained to me, and any questions I have regarding the treatment have been explained to my satisfaction.

_____ I understand that with any treatment certain risks are involved and that any complications from known or unknown causes could occur.

_____ I understand that possible side effects include, but are not limited to: mild to moderate redness, mild to moderate peeling or flaking, stinging, dry skin, tenderness, pimples, cold sores or allergic reactions. Most side effects are temporary and will dissipate within 3-7 days.

_____ I do not have active cold sores.

_____ I will call to inform my skincare professional of any complications or concerns I may have as soon as they occur.

_____ I understand that it is recommended prior to having a facial infusion to *not* have used Retin A for 48 hours, Accutane in 6 months, or have waxed 24 hours prior to receiving treatment.

_____

CLIENT SIGNATURE PRINT NAME DATE

TECHNICIAN NOTES:

Treatment Receiving Today (check one):

SKIN RITUAL: _____ **DATE:** _____

MODALITIES: _____ **DATE:** _____

Notes:

I have reviewed the treatment and post care instructions to the client stated above and answered any questions.

_____

TECHNICIAN SIGNATURE DATE