BELLA BEAUTY BY DANIELLE NICOLE CLIENT PROFILE AND MEDICAL HISTORY

Name:	**DOB:**	**Age:**	**Height:**
Address:			
Email:			
Phone:	**Emergency Contact** (Name/Phone)**:**		
Describe any aesthetic services you've received in the last 6 months:			
Have you consumed at least 1 liter of water today prior to treatment? ___Yes ___No, but I will have some now			
How did you hear about BELLA BEAUTY BY DANIELLE NICOLE?			

1. Check if you have or had any of the following, if yes briefly explain:

- Pregnant
- Breast Feeding
- HIV/AIDS
- Bleeding Disorders
- High Blood Pressure
- High Cholesterol
- Liver Disorders
- Skin Disorders
- Respiratory Disorders
- Neurological Disorders
- Cardiac Disorders
- Lymphatic Disorders
- Psychological Diagnosis
- Diabetes
- Pace Marker or Devices in Body
- Metals in Body
- Seizures
- Cancer
- Acute illness (cold/flu/diarrhea/etc.)
- Other: _____

2. Describe **all surgeries** and the year you received them:

_____

_____

3. List **all allergies** and your reactions:

_____

_____

4. List all **medications/herbs/supplements** currently or recently taken:

_____

5. List any **medical or non-medical** condition your technician should be aware of:

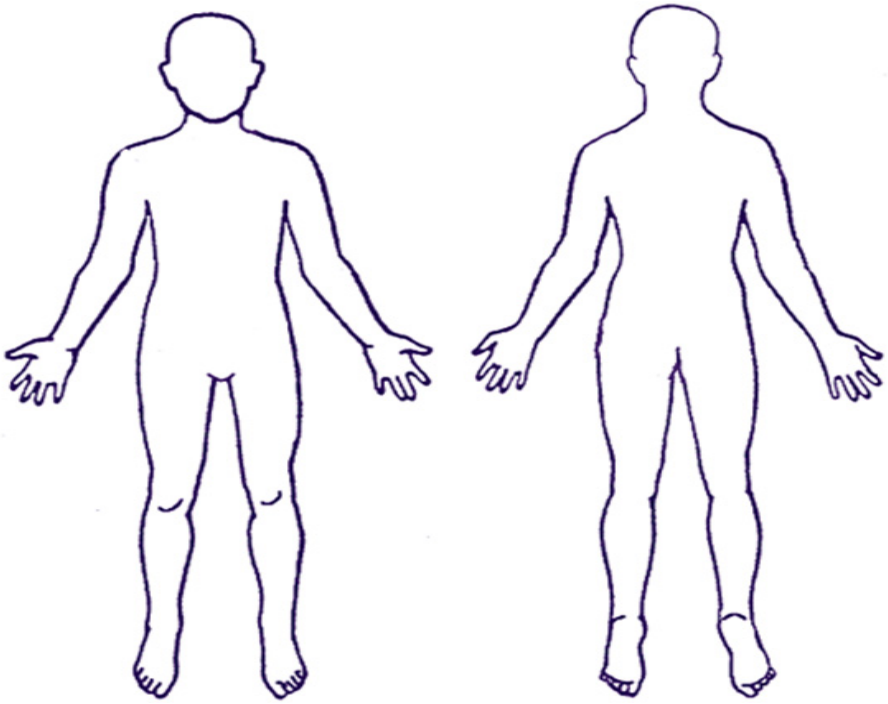
6. Specific Appearance problems and treatment goals:

SKIN DESCRIPTION	
Skin Condition: ___Dry ___Oily ___Normal ___Acne Prone	**Ethnicity:**
Is your skin fragile or sensitive, if yes?	
Do you have problems healing from injury to skin, if yes describe?	
Have you ever had a cold sore?	
Are you primarily inside or outside?	
Do you currently use sun block regularly?	

By signing below, I verify that I am in good physical condition and the information documented is accurate and complete. I have no physical restriction, condition, or disability which may prevent me from receiving the prescribed skin care and/or body treatment therapies. I hereby give my consent to have the recommended procedures performed on me.

Name of Client **Signature** **Date**

Front Back



DATE:		**DATE:**		**DATE:**		**DATE:**	
Weight		Weight		Weight		Weight	
Bust		Bust		Bust		Bust	

Upper ABD		Upper ABD		Upper ABD		Upper ABD	
Lower ABD		Lower ABD		Lower ABD		Lower ABD	
R/L Arm		R/L Arm		R/L Arm		R/L Arm	
R/L Thigh		R/L Thigh		R/L Thigh		R/L Thigh	
DATE:		**DATE:**		**DATE:**		**DATE:**	
Weight		Weight		Weight		Weight	
Bust		Bust		Bust		Bust	
Upper ABD		Upper ABD		Upper ABD		Upper ABD	
Lower ABD		Lower ABD		Lower ABD		Lower ABD	
R/L Arm		R/L Arm		R/L Arm		R/L Arm	
R/L Thigh		R/L Thigh		R/L Thigh		R/L Thigh	

Informed Consent for Non-Surgical
Body Contouring/Skin Therapies//Wood Therapy

I understand that certain procedure(s) elected are relatively new and little is known about their long-term safety and effectiveness. I understand that each person has a different response to Body Contouring.

I understand that the procedure(s) do not correct health problems, including but NOT limited to diabetes, heart attack, stroke, high cholesterol, blood clots, lung problems, stomach, intestinal problems, bladder disease, and an abnormality of the skin. **BELLA BEAUTY BY DANIELLE NICOLE** is NOT a medical facility and does NOT make medical decisions. You must consult with your Primary Care Physician for medical advice.

I understand that I may need post procedure care. I will dutifully be responsible and compliant with the recommendations from my **BELLA BEAUTY BY DANIELLE NICOLE** Clinician, which may include, but are not limited to skin care products, garments, etc.

I understand that procedures involve risk. Risk may include, but not limited to redness, swelling, irritation, burns, skin reactions, etc. I must immediately report any unusual symptoms known to me to my **BELLA BEAUTY BY DANIELLE NICOLE** Clinicians that includes, but NOT limited to being aware of any slight nature or prominence of persistent chills, fever, redness, increased warmth, excessive bruising or swelling, etc. at the sights treated and systematically.

I give **BELLA BEAUTY BY DANIELLE NICOLE** permission to use data about my treatment for research purposes.

I understand that my name and personal identifying information will remain confidential unless I have written permission to disclose this information. I give **BELLA BEAUTY BY DANIELLE NICOLE** professional permission to photograph/video my procedure(s).

I have decided that the benefits of body contouring outweigh the potential for complications and all claims have not been evaluated by any regulatory board. I understand the nature of the procedure(s) and ANY and all possible risks mentioned and not limited to. I attest that I am of clear mind, competent, and not under any distress.

ALTERNATIVE TREATMENTS

It has been explained that other temporary and more permanent treatments are available to sculpt, contour, tone, exfoliate, clean and detoxify the body. Alternative forms of management include receiving NO treatment at all. If treatment is chosen alternative body sculpting therapies and other services offered include the following: Lipo Laser, Ultrasound Cavitation, Vacuum Therapy, Wood Sculpt, Electrotherapy, Vibration, Cold/Hot Wraps, Infrared Rays, Reduction Massage, Lymphatic Drainage. I understand that risk and potential complications are associated with these and alternative forms of non-surgical and surgical treatments.

CANCELLATION POLICY

If there is a need to cancel for any reason, we ask for a 24-hour notice. **"NO SHOW"** for appointments made outside of normal business hours **WILL** result in a service charge deductible from the prepaid service package. Remaining balance will be applied towards the next service appointment with regards to TIME LIMITS FOR SERVICE AGREEMENT. _____**(Initial)**

TIME LIMITS FOR SERVICE

Specials, Flash Sales & Promotional Priced Services **MUST BE** completed within 30 days of purchase date. _____**(Initial)**
Regular Price Services **MUST BE** completed within 60 days of purchase date. _____**(Initial)**

RELEASE OF LIABILITY

I hereby certify that I am not pregnant or nursing.

I understand that **NO GUARANTEES OR WARRANTIES** have been made to me regarding the outcome or any improvements to my condition due to the procedure(s) I have elected to undergo. I am paying for a service and not desired results from treatments. I have been given the opportunity to ask questions and have received satisfactory answers to those questions by the treating staff representative. _____**(Initial)**

I consent to the taking of photographs/video for documentation during my treatment(s) unless otherwise stated with written notice to **BELLA BEAUTY BY DANIELLE NICOLE.** These photos may be used for marketing and/or publication for the further benefit of educating the public. All attempts will be made to protect my identity. _____**(Initial)**

I agree to indemnify, hold harmless and release **BELLA BEAUTY BY DANIELLE NICOLE** its employees,

members, representatives, affiliated organizations, and others acting on the Company's behalf of all claims, demands, causes of action and legal liability, whether the same be known or unknown, anticipated or unanticipated. I further agree that except in the events of the Company's gross negligence or willful misconduct, no claims, demands, legal actions and causes of action shall be made against the Company for any economic and non-economic losses of any kind. _____**(Initial)**

Finally, I certify that I have read and fully understand the contents of this form and that the disclosures referred to above were made prior to my signing the form below. _____**(Initial)**

NO REFUND OR RETURN POLICY. ALL SALES ARE FINAL

I ACKNOWLEDGE THAT I HAVE HAD A FAIR OPPORTUNITY TO ASK QUESTIONS ABOUT PUT YOUR BUSINESS NAME HERE'S PROCEDURES FOR BODY CONTOURING AND THE ALTERNATIVE TREATMENTS AVAILABLE. I ALSO ACKNOWLEDGE THAT MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I UNDERSTAND AND ACCEPT THE POTENTIAL RISKS AND COMPLICATIONS INVOLVED.

_____

Name of Client

_____ _____

Signature **Date**