**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_

**Emergency Contact (1):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact (2):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What Procedure(s) Are You Interested In?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had any of the following conditions? (check all that apply)**

|  |  |
| --- | --- |
| o allergy/hay fever  o anemia  o arthritis/rheumatism  o asthma  o back problems/pain  o bleeding problems  o blood disease  o blood transfusion  o bone or joint pain  o cancer  o chemotherapy  o diabetes  o dizziness/fainting  ○ drug or alcoholism  o epilepsy  o eye injury or disease  o headaches  o heart disease  o head injury  o hepatitis  o herpes  o high blood pressure / low blood pressure  o HIV | o infection (active)  o kidney disease  o keloid  o liver disease  o lupus  o melanoma  o mental disorder  o migraines  o mitral valve prolapse  o nervousness  o radiation treatment  o respiratory problems  o shingles/past outbreak  o shortness of breath  o skin conditions  o sinus problems  o swollen feet/ankles  o stroke  o thyroid problems  o tuberculosis  o ulcers  o varicose veins  o venereal disease  o any other conditions not listed \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **List all current medications/supplements:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Allergies (medications, cosmetics, latex/other):**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |  |  |
| --- | --- | --- | --- |
| **Have you ever or currently using?**  Retinol  Accutane  Prescription acne medication  Birth control  Steroids  Insulin/Diabetic medications | **Last Date Used:**  Date:\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_ | **Please note treatments below:**  Laser treatments  Tanning (last 2 weeks) | **Last Date Used:**  Date:\_\_\_\_\_\_\_\_  Date:\_\_\_\_\_\_\_\_ |

**The above information is true to the best of my knowledge.**

**PATIENT SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INFORMED CONSENT**

**Treatment Information:**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [Client's Name], hereby consent to receive treatments/services at Beauty and Body by Flora.

**Potential Risks and Side Effects:**

I understand that while the staff at Beauty and Body by Flora will take all necessary precautions, there are inherent risks associated with the treatment/services listed above. These risks may include, but are not limited to:

* Allergic reactions
* Redness or swelling
* Bruising
* Infection
* Scarring
* Changes in skin texture or color
* Unsatisfactory results

**Consent to Treatment:**

I hereby give my consent to Beauty and Body by Flora and its staff to perform the selected treatment/services. I understand that I have the right to ask questions and seek clarification about the treatment/services, including any associated risks and side effects, before proceeding.

**Patient Informed Consent**

At Beauty and Body by Flora, your health and safety are our top priorities. To ensure the best possible outcomes for treatments, it is imperative that the patient disclose any health information that may affect your procedure(s) at Beauty and Body by Flora. This includes, but is not limited to, allergies, medications, medical conditions, and treatments provided by Beauty Body by Flora. You are obligated to follow pre and post-procedure instructions which include promptly informing us of any adverse reactions or unexpected symptoms following your treatment in order for us to respond swiftly and appropriately.

**Benefits and Expected Results:**

I understand that the benefits and expected results of the treatment/services may vary depending on factors such as my skin type, medical history, and adherence to post-treatment instructions. I have discussed my expectations with the staff at Beauty and Body by Flora, and I understand that realistic outcomes have been explained to me.

**Financial Responsibility:**

I understand that I am responsible for the full payment of the selected treatment/services, as well as any additional charges incurred during or after the procedure. I have been informed of the cost of the treatment/services, and I agree to pay the specified amount.

**Confidentiality:**

I understand that my personal and medical information will be kept confidential in accordance with applicable laws and regulations. I authorize Beauty and Body by Flora to use my information for treatment purposes and billing/administrative purposes.



**PATIENT SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**