



FACIAL TREATMENT

Skin Analysis

Client Information:

Name: _____ Date of birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Skin Analysis

Skin Type:

Normal Oily Dry Sensitive Combination

Pores:

Fine Dilated Comedones Milia

Moisture Content:

Excellent Good Fair Poor

Elasticity:

Excellent Good Fair Poor

Acne:

No I II III IV

Skin Sensitivity:

Normal Sensitive Hyper sensitive

Face Lines (Glogau Scale):

I-None II - Wrinkles in Motion III- Wrinkles at rest IV- Mostly Wrinkles

Any other conditions: _____

Any known allergies? Yes No: _____

List any medications you take regularly including vitamins, herbal supplements, aspirin:

List any previous treatments:

Life Style: Active Sedentary

Notes: _____



FACIAL TREATMENT

Client Consent Form

I hereby consent to and authorize Conchetta Dixon to perform the following procedure:

I have voluntarily chosen to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks and hazards involved, by

Although it is impossible to list ever potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle and that there is the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.

I have read and understand the post- treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment or suggested home product/post - treatment care, I will consult the esthetician immediately.

I have also, to the best of my knowledge given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and understand this agreement and all information detailed above. I understand the procedure and accept the risks. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by treatment performed today.

Client Printed

Date

Client Signature

Esthetician

Date



FACIAL TREATMENT

Photo and Video Release Form

I, _____ hereby grant and authorize Conchetta Dixon the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures, videos and/or audio taken of me to be used in and/or for any lawful promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, press kits, websites, social media sites and other print and digital communications, without payment or any other consideration.

This authorization shall continue indefinitely and extends to all languages, media, formats and markets now known or later discovered.

I waive any rights to royalties or other compensation arising or related to the use of the photograph recording.

I understand and agree that these materials shall become the property of the Esthetician and will not be returned.

I hereby hold harmless and release Conchetta Dixon from all liability, petitions, and causes of action which I, my heirs, representatives, executors, administrators, or any other persons may make while acting on my behalf or on behalf of my estate.

By signing below, I hereby acknowledge that I have completely read and fully understand the above release agreement.

Client Printed

Date

Client Signature



FACIAL TREATMENT

Appointment Cancellation Policy

Our goal is to provide quality care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy.

Appointments are in high demand, and your early cancellation will give another person the opportunity to have access to timely care. This policy enables us to better utilize available appointments for our clients.

At the time of booking your appointment you will be asked to pay a YOUR RATE HERE deposit that will be credited towards your treatment/s.

Time has been specifically reserved for your appointment, procedure, or treatment. If you need to cancel or reschedule your appointment you must call at least 24 hours prior to your appointment and your deposit will either be refunded or pushed for a future appointment. However, providing less than 24 hours notice will require you to pay a YOUR AMOUNT HERE cancellation fee.

If you arrive more than 15 minutes late for your appointment it is considered a no-show and you will be charged the cancellation fee.

We are happy to answer any questions regarding this cancellation policy.

I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by its terms. I agree to pay the cancellation fee in the event of a missed appointment.

Client Printed

Date

Client Signature

FACIAL TREATMENT

aftercare advice



Avoid make up and facial products for the rest of the day.



Do not use scrubs or abrasive skincare products for 72 hours.



Change your pillowcase before bed. Don't sleep with makeup on.



Stay away from direct heat such as sunbathing and saunas for 48 hours



Only go for one skincare treatment at a time.



Refrain from drinking alcohol and smoking for 72 hours. Drink 6-8 glasses of water.



Continue your skin care routine



Do not miss your next appointment



Maintain a healthy diet

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aftercare advice



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