Humber Bay Shores
Beauty & Spa

FIRST NAME	LAST NAME	EMAIL
CELL/HOME TELEPHONE	**DOCTOR**	**HOW DID YOU HEAR ABOUT US**

PLEASE CIRCLE WHERE APPROPRIATE BELOW ✓ **under Y or N➔**	Y	N
Metal Plates in Your **Body** or **Head**, if yes, circle where and complete next question		
Any alloy orthopedic implants➔cobalt-chrome, stainless steel, titanium, etc.		
Heart Issues/Pacemaker (Please note this is a contra-indication)		
Varicose Veins (if yes, please specify where)		
Hemophilia/Thrombosis/Epilepsy (if yes, state/circle which one applies)		
Have you had any body contouring/sculpting previously (if yes, state which one and when)		
➔		
Any surgery or illness within past 12 months (if yes, please specify)		
Are you allergic to latex?		
Are you currently taking any pain relievers?		
Cancer (if yes, please specify where and if current)		
Are you on any life-saving medication (if yes, please specify)		
I AGREE TO REMOVE ALL JEWELLERY INCLUDING BELLY/TONGUE/TOE/ RINGS, EARRINGS, WATCHES, NECKLACES, ETC. and will be held solely accountable if I do not		
FEMALE CLIENTS ONLY		
Pregnant / Breastfeeding or trying to become pregnant / Age of youngest child – must be over 6 weeks		
Caesarian Section min 6 months / Hysterectomy / Tumors or Ovarian Cysts		
I.U.D. Coil (if yes, please specify if coil contains copper or other metal)		
FACIAL HISTORY for EMS FACE & CELLUMA		
Do you have Epilepsy / Seizures		
Are you on Retin A / Cortisone / Steroid Injections (wait 1 week) / Accutane (wait 6 months)		
Any Fillers Juvéderm/Botox Injections within past 3 weeks (if yes, please specify where)		
Metal Plates & Pins in the Head, Face or Neck / Metal Fillings (teeth) (if yes, please specify where)		
Do you have Photosensitivity to medications		

PHOTO CONSENT & RELEASE FORM

I the undersigned do hereby agree to the following. I am allowing any member of Humber Bay Shores Beauty & Spa to take photos of my treatment and/or treated areas to be used for the purpose of monitoring my progress. In addition:

I give permission for my photos to be used for education and advertising	**please initial -->**	
At my request, my identity will remain anonymous	**please initial -->**	
At my request, my photos will only be used for my chart	or **please initial -->**	

DECLARATION (Please Read Carefully)

I have read and understand all the questions and know of no reason why I should not be in a position to use Slimwave. I understand I do so at my own risk and cannot hold Slimwave/Humber Bay Shores Beauty & Spa or the Operator responsible if I withhold or supply incorrect information. If I experience any pain or discomfort during the session, I will immediately inform the technician so that technique and or intensity may be adjusted to my level of comfort. I understand that Slimwave technicians are not qualified to perform, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because certain treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the Slimwave technician updated as to any changes in my medical profile during these treatments and understand that there will be no liability on the Slimwave/Humber Bay Shores Beauty & Spa or the Operator/technician part should I fail to do so. All packages sold are provided on a non-refundable basis but can be transferred to another client or substituted with another service and have no expiry date. **Please initial here. ➔**

PRINT NAME	SIGNATURE	DATE

COVID-19 VIRUS PANDEMIC CLIENT VISITATION DECLARATION, RELEASE, INDEMNITY, & HEALTH DISCLOSURE

Client In-Person Visitation of Premises at **Humber Bay Shores Beauty & Spa** (the "Premises"), on _____ (date) at _____ (time). Advanced Medical Spa Therapist/Electro-Therapist: Joya Salvadori Phone Number: 647.328.5324

CLIENT DECLARATION, RELEASE & INDEMNITY: I acknowledge and agree as follows:

1. I am requesting that my Therapist arrange for in-person treatment. I do so voluntarily and of my own free will without any coercion by any person or company and being fully aware that we are in the midst of a COVID-19 virus pandemic and the virus appears to be highly contagious.

2. I fully understand that by seeking in-person access to the premise, there is a risk I may be exposing myself to the potential transmission of the COVID-19 virus to myself, my family or my friends. I knowingly, freely and voluntarily accept the inherent risks of this activity, including possible contamination, illness or death.

3. I have been fully advised by my Therapist of the risks involved related to in-person property visitation during the COVID-19 virus pandemic and I take full responsibility for any negative consequences resulting from continuing this activity at this time;

4. I agree to indemnify, save harmless, release, discharge, acquit and forgive my Therapist as specified above, and their business, as well as the Therapist(s) and the clinic for the session performed and future sessions performed, from any and all liability, claims, actions, suits, demands, costs or expenses of any kind, as related to any health risks or adverse health related consequences, arising as a result of my visitation at the subject property.

CLIENT HEALTH DISCLOSURE: Prior to entering this property please consider the health and safety of others.
Therapist Representative: Joya Salvadori - I confirm the following statements to be true for my current visit and should my future visits and COVID symptoms change (re. A-C below) I will cancel my appointments accordingly (***check all that apply***):

☐ A. I have not recently travelled anywhere outside of Canada or been in contact with anyone who has travelled outside of Canada.

☐ B. I have not experienced any of the following symptoms in the last 14 days: fever, dry cough, shortness of breath, or difficulty breathing.

☐ C. I have not come into contact with anyone with a confirmed COVID-19 diagnosis in the last 14 days.

ACCESS TO THIS LOCATION WILL NOT BE GRANTED FOR ANY THERAPIST OR CLIENT WHO HAS EITHER NOT COMPLETED THIS FORM, OR HAS BEEN UNABLE TO CHECK ALL OF THE ABOVE 3 CRITERIA.

Client Declaration, Release & Indemnity Acceptance Signature: _____

Full Name (please print): _____Witness Signature:_____