

Informed Consent To Rejuvenation Treatments

I hereby request and consent to the performance of rejuvenation treatments, including application of electrical stimulation, color light therapy, sound waves and skin care products on me (or on the client/patient named below, for whom I am legally responsible) by the health care or esthetic practitioner named below and/or other professionals and their assistants who now or in the future treat me while employed by, working, or associated with the health care or esthetic professional named below.

I have had an opportunity to discuss with the practitioner named below and/or with other office or spa personnel the nature and purpose of rejuvenation services and other procedures. I understand that results are not guaranteed.

I understand and am informed that, in the practice of rejuvenation services, there are some risks with treatment, including, but not limited to, bruising, swelling, skin irritation or discoloration, fainting and/or dizziness, and headaches. I understand that such reactions are unlikely and rare, but possible. Discomfort due to the process of detoxification triggered by the therapeutic current and/or light is also possible. I take responsibility to tell the practitioner about any health concerns I have about receiving treatment, and will specifically will inform the practitioner if I am subject to any epileptic or seizure disorder, for which rejuvenation services are contraindicated.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to receive the above-named procedure. I intend this consent form to cover the entire current course of treatment, and any future courses of treatment I seek.

To be completed by client:

Print Client's Name

Signature of Client

Date Signed

*To be completed by client's representative, if necessary
e/g, if client is a minor.*

Print Name of Client

Print Name of Client's Representative

Signature of Client's Representative

As: _____
Relationship of Authority of Client's Representative

Date Signed

Name and Address of Practitioner:

Witness To Client's Signature: _____