

Facial Consent Form

CLIENT INFORMATION:

Name: _____

Address

Phone Number: _____ Date of Birth: _____ dd / mm / yyyy

TREATMENT DESCRIPTION:

Procedure(s) to be performed

Products to be used

Esthetician's Name: _____

MEDICAL HISTORY:

Please list any known allergies, skin conditions, current medications, previous facial treatments, or other relevant medical information

Acknowledgment of Risks: I understand that some discomfort, redness, or other side effects may occur due to this treatment. I have discussed these risks with my esthetician and understand them thoroughly.

Client Expectations and Goals

Cancellation and No-Show Policy: Appointments must be canceled at least 24 hours in advance. If you cancel your appointment less than 24 hours before the scheduled time or do not attend, a fee will be charged. This policy ensures we can accommodate other clients and maintain the schedule efficiently.

Privacy Statement: I understand how my personal and medical information will be used and protected. Your personal and medical information will be kept strictly confidential and only be used for your treatment and care. This information will not be shared with third parties without your explicit consent, except as required by law or in the case of a medical emergency. All records will be stored securely, and reasonable precautions will be taken to protect your information from unauthorized access or disclosure. You have the right to request access to your records at any time.

Photography Consent: I consent to taking before-and-after photographs of my face to document the treatment results and for use in the esthetician's portfolio, marketing materials, social media, and/or website. I understand that my name and other identifying information will not be used with these photographs without my written consent. If I choose not to consent to the use of photographs for these purposes, it will not affect the quality or delivery of my treatment in any way.

Photography Consent Choice

☐ I consent to the use of photographs as described above ☐ I do not consent to the use of photographs as described above

Consent Statement: I have read and understood the above information and voluntarily consent to the facial treatment described. I release the esthetician and the facility from all liabilities of this treatment.

SIGNATURE:

Client Signature
Client Signature Date: _____ dd / mm / yyyy

Esthetician Signature
Esthetician Signature Date: _____ dd / mm / yyyy