Galvanic Facial

GALVANIC FACIAL

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DISCLAIMER

Treatment OverviewA galvanic facial is a non-invasive skincare treatment that uses a low-level electrical current to stimulate, refresh, and rejuvenate the skin. The treatment typically involves two key processes: Desincrustation – A deep cleansing phase that softens sebum and removes impurities from the skin. Iontophoresis – A product infusion stage where positive and negative currents help active ingredients penetrate deeper into the skin layers.The galvanic current assists in improving circulation, enhancing the absorption of skincare products, and promoting a more radiant, hydrated, and youthful appearance.

Potential BenefitsDeep cleansing of pores and removal of impuritiesImproved skin hydration and nourishmentEnhanced absorption of active skincare ingredientsFirmer and more toned skin appearanceReduction in dullness and improved complexionResults vary from person to person and depend on skin condition, age, and overall skincare routine.

Possible Risks and Side EffectsWhile generally considered safe, galvanic facials involve mild electrical stimulation, which may cause temporary reactions such as:Redness or mild irritationTingling or slight discomfort during treatmentTemporary dryness or tightness of the skinSlight swelling in sensitive areasRarely, more noticeable irritation or allergic reactions to skincare products used may occur. If any prolonged discomfort, rash, or swelling develops, please contact your practitioner immediately.

ContraindicationsThis treatment is not suitable for individuals with:Pacemakers or other electrical implantsHeart conditions or epilepsyMetal implants or bracesPregnancyOpen wounds, cuts, or severe acneSkin infections or inflammation in the treatment areaPlease inform your practitioner of any medical conditions, allergies, or medications you are currently taking.

I have been advised of the relevant information associated with this treatment and I confirm that I fully understand this advice. This includes advice about:- the aims/motivations for having the procedure and the desired outcome- the risks inherent in the procedure- the risks inherent in refusing the procedure- the risks specific to me- the expected benefits of the treatment- the potential disadvantages of the treatment- alternative procedures and their pros and cons - including the option of no treatment at all- any uncertainties about and the likelihood of success of the procedure- any follow-up treatment that may be requiredCLINICAL PHOTOS AND VIDEOS: I agree to and authorise the taking of clinical photographs and videos. I understand that these clinical photographs and videos will form part of and will be kept with my confidential medical records.I have been asked what information I want and would need in order to make an informed decision. I have been given the opportunity to discuss my desired outcome fully in order for me to make an informed decision. I certify that I have read the above consent and that I fully understand it. I have been given ample opportunity for discussion, and all my questions have been answered to my satisfaction. No new information has become available that affects my decision to have the treatment or my decision to consent. I hereby consent to this procedure. This constitutes the full disclosure and supersedes any previous verbal or written disclosures. All deposits and booking fees are non-refundable unless agreed to with the practitioner.

Do you understand the information you have been provided?

◯ Yes ◯ No

Do you feel sufficient information has been provided to you, to enable you to consent?

◯ Yes ◯ No

Has your consent been freely given?

◯ Yes ◯ No

Do you have any medical conditions?

◯ Yes ◯ No

Are you pregnant or breastfeeding?

◯ Yes ◯ No

Do you have a neuromuscular disease (e.g. MS, ALS, motor neuropathy myasthenia gravis, or Lambert-Eaton syndrome)?

◯ Yes ◯ No

Do you have an autoimmune disease?

◯ Yes ◯ No

Do you have any skin conditions?

◯ Yes ◯ No

Do you have any known allergies or have ever had anaphylaxis?

◯ Yes ◯ No

Do you have any active infection at the intended site of procedure?

◯ Yes ◯ No

Are you taking antibiotics or other prescription medications?

◯ Yes ◯ No

Is there any other Medical and/or Social History that we should know? If so, please provide full detail here.

What are your aims/motivations for having the procedure and the desired outcome? Please provide full details here.

Have you had this or a similar treatment before? If so, did you experience any problems? Please provide full details here.

Do you have any concerns? If so, please provide full details here.

Is there anything else we should know? Please provide full details here.

I will retain this information throughout the course of my treatment and refer to it as required.