DISCLAIMER

THE FORMS PROVIDED ARE FOR INFORMATIONAL PURPOSES ONLY AND SHOULD NOT BE CONSIDERED LEGAL ADVICE. THESE FORMS MAY NOT BE SUITABLE OR APPROPRIATE FOR YOUR SPECIFIC SITUATION AND JURISDICTION. IT IS IMPORTANT TO CONSULT WITH A LICENSED ATTORNEY TO ENSURE THAT THE FORMS MEET YOUR SPECIFIC LEGAL REQUIREMENTS AND TO ENSURE THAT THEY ARE LEGALLY BINDING. THE USE OF THESE FORMS DOES NOT ESTABLISH AN ATTORNEY-CLIENT RELATIONSHIP AND ST. LISSE SHALL NOT BE LIABLE FOR ANY LOSSES OR DAMAGES RESULTING FROM THE USE OF THESE FORMS.

RF MICRONEEDLING

CONSULTATION FORM

GENERAL INFORMATION

Full name: _____ Date of birth: _____

Address: _____

Phone: _____ Email: _____

Emergency contact name: _____ Phone: _____

What is your gender? ◯ Male ◯ Female ◯ Non-binary ◯ Other

Would you like to be added to our email list for specials and discounts? ◯ Yes ◯ No

HEALTH HISTORY

Is this the first time receiving RF microneedling treatment? ◯ Yes ◯ No

If 'No', when and where was your last treatment: _____

Do you have a history of any of the following medical conditions:

- ◯ Diabetes
- ◯ Heart disease
- ◯ Blood disorder(s)
- ◯ Autoimmune disorders
- ◯ Skin infections/disease
- ◯ Keloid scarring
- ◯ Cold sores/herpes simplex virus
- ◯ Cancer/tumor
- ◯ Cardiovascular problems
- ◯ Dislocations
- ◯ Epilepsy
- ◯ High blood pressure
- ◯ HIV/AIDS
- ◯ Hypertension
- ◯ Kidney disease
- ◯ Liver disease
- ◯ Lupus
- ◯ Metal implants
- ◯ Pacemaker
- ◯ Pregnant/nursing
- ◯ Rosacea
- ◯ Sunburn/suntan
- ◯ Transplant(s)
- ◯ Thyroid disease
- ◯ Undergoing chemotherapy
- ◯ Varicose veins
- ◯ Other

If 'Other', please detail: _____

Do you have photosensitivity to sun exposure? ◯ Yes ◯ No

Do you wear glasses or contact lenses? ◯ Yes ◯ No

Are you taking any medications (orally or topically)? ◯ Yes ◯ No

If 'Yes', please detail: _____

Do you have any allergies? ◯ Yes ◯ No

If 'Yes', please detail: _____

RF MICRONEEDLING CONSULTATION FORM

(continued)

Have you had any surgeries in the last 6 months? ◯ Yes ◯ No
If 'Yes', please detail: _____

Please list the products you use regularly:

Facial cleanser: _____ Sunscreen: _____
Moisturizer: _____ Retinol: _____
Toner: _____ Glycolic acid: _____
Serum: _____ Enzymes: _____
Scrubs: _____ Peptides or growth factors: _____

Have you ever had any of the following injectables or implants?

◯ Botox ◯ Restylane ◯ Collagen
◯ Juvederm ◯ Perlane ◯ Sculptra
◯ Radiesse ◯ Silicone ◯ Dysport

Other: _____
If 'Yes', when? _____ What body area(s) _____

Certain conditions may affect how appropriate the treatment is. Please declare all relevant history as some conditions contraindicate the treatment.

Please read and sign below:

◯ *I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the esthetician of my current medical or health conditions and to update this history. A current medical history is essential to carry out appropriate treatment procedures.*

_____	_____	_____
CLIENT NAME (PRINTED):	CLIENT NAME (SIGNATURE):	DATE:
_____	_____	_____
TECHNICIAN NAME (PRINTED):	TECHNICIAN SIGNATURE:	DATE:

RF MICRONEEDLING

CLIENT CONSENT FORM

I, _____ , understand and acknowledge that I am considering undergoing a cosmetic procedure known as RF Microneedling. I have been provided with the necessary information about the procedure, its potential risks, benefits, and alternatives. I have had the opportunity to ask questions, and my questions have been answered satisfactorily. I hereby provide my informed consent to undergo RF Microneedling under the following terms and conditions:

RF Microneedling is a non-surgical cosmetic procedure that combines radiofrequency (RF) energy and microneedling techniques to treat various skin concerns. The procedure involves the use of a specialized device that emits RF energy through small needles, creating controlled micro-injuries in the skin. This process stimulates collagen production and enhances the rejuvenation and tightening of the skin.

PURPOSE & EXPECTED BENEFITS

The purpose of RF Microneedling is to improve the overall appearance and texture of the skin. The potential benefits may include the reduction of fine lines, wrinkles, acne scars, stretch marks, hyperpigmentation, and skin laxity. It may also enhance skin tone and stimulate collagen remodeling, resulting in a more youthful and rejuvenated appearance.

POTENTIAL RISKS & COMPLICATIONS

While RF Microneedling is generally considered safe, it is essential to be aware of potential risks and complications, which may include but are not limited to the following:

- Temporary redness, swelling, and bruising at the treatment site.
- Mild discomfort or pain during the procedure.
- Temporary skin sensitivity, dryness, or flaking.
- Temporary hyperpigmentation or hypopigmentation.
- Infection or scarring (rare).
- Allergic reactions or skin reactions to topical products.
- Unsatisfactory results, asymmetry, or dissatisfaction with the outcome.
- Rare instances of more severe complications may occur, but they are extremely rare.

PRE-TREATMENT INSTRUCTIONS

I agree to follow all the pre-treatment instructions provided by my healthcare provider, which may include but are not limited to:

- Avoiding direct sun exposure and tanning beds.
- Discontinuing the use of certain medications, such as blood thinners, as advised.

RF MICRONEEDLING CLIENT CONSENT FORM

(continued)

- Informing my healthcare provider about any current or past medical conditions, allergies, or medications.
- Cleansing my skin thoroughly before the procedure as instructed.

TREATMENT PROCESS

I understand that the RF Microneedling procedure will be performed by a qualified healthcare professional. The steps involved in the treatment may include:

- Cleansing and preparing the treatment area.
- Applying a topical anesthetic to ensure my comfort.
- Administering the RF Microneedling device on the targeted areas, including multiple passes as necessary. Adjusting the depth and intensity of the treatment based on my specific needs.
- Ensuring appropriate cooling and post-treatment care.

POST-TREATMENT CARE

I agree to adhere to the post-treatment care instructions provided by my healthcare provider, which may include but are not limited to:

- Applying a soothing and protective ointment as instructed.
- Avoiding direct sun exposure and using sunscreen regularly.
- Avoiding harsh skincare products and procedures during the healing process.
- Keeping the treated area clean and moisturized.
- Reporting any unusual or concerning symptoms to my healthcare provider.

I have read and understood the information provided in this consent form for RF Microneedling. I have had the opportunity to ask questions, and all my concerns have been addressed satisfactorily. I consent to undergo RF Microneedling based on the information provided, understanding the potential risks and benefits associated with the procedure.

CLIENT NAME (PRINTED):	CLIENT NAME (SIGNATURE):	DATE:
TECHNICIAN NAME (PRINTED):	TECHNICIAN SIGNATURE:	DATE:

RF MICRONEEDLING

PRE-TREATMENT INSTRUCTIONS

- Do not use topical agents that may increase sensitivity of skin: retinoids, topical antibiotics, exfoliants, acids that may be drying or irritating to the skin (such as alpha hydroxyl acid (AHA), beta hydroxyl acids (BHA), exfoliating masks, salicylic acids, hydroquinone, and benzoyl peroxide acne products) 5-7 days prior.
- This treatment cannot be done when pregnant, or if you have an electronic implant (Insulin pump, pacemaker, LVAD, etc)
- Let your skincare specialist know if you have been diagnosed with cold sores or Herpes simplex.
- Do not take any anti-inflammatory medications such as ibuprofen, Motrin, Aspirin, or Advil for 5-7 days prior to treatment. These agents will interfere with the natural inflammatory process that is critical and responsible for your skin rejuvenation.
- No IPL/Laser procedures, self-tanning lotions or tanning booths, unprotected sun exposure, or sunburn for 2 weeks prior.
- No waxing, depilatory creams, or electrolysis to area being treated 5-7 days prior.
- No shaving the day of the procedure to avoid skin irritation. If there is dense hair present in treatment area, closely shave the area the day before you arrive to your appointment. Moles, wart actinic (solar) keratosis cannot be treated.
- Please arrive to your appointment without make-up, creams, gels, or lotions on treatment areas.

RF MICRONEEDLING

POST-TREATMENT INSTRUCTIONS

- A certain degree of discomfort, redness, and/or irritation during and after treatment is expect should not persist for more than 24 hours after treatment. After 12-hours post procedure, hydroco cream may be applied 3-4 times per day to reduce redness.
- Do not take any anti-inflammatory medications such as ibuprofen, Motrin, Aspirin or Advil for 1 wee
- Tylenol only as needed for any soreness.
- Do not apply ice to your face.
- Avoid strenuous exercises that cause sweating, jacuzzi, sauna, or steam baths for 24 hours due to ope pores, or up to 48 hours if inflammation exists.
- Avoid excessive heat, tanning beds, and sun exposure for a minimum of 2 weeks post treatment. If you must be in the sun, apply SPF 30 or greater, reapply every 2 hours, wear a hat, and seek shade when possible.
- Very small scabs may form 24-72 hours post treatment and may remain for several days. The scabs should not be touched or scratched (even if they itch) and should be allowed to shed naturally.
- Peeling may start 3-5 days after treatment. You will notice skin dryness and flaking. This is due to an increased turnover of skin cells. Do not pick or prematurely peel the skin, as this will cause hyperpigmentation and/or surface scars. Allow old skin to flake off naturally and keep skin moisturized at all times.
- Sleep on your back with head of bed elevated to minimize swelling or pain as needed.
- Avoid surfaces that could irritate your skin such as: pillows, beards, collared or turtleneck shirts.
- Make sure you're using a clean pillowcase so dirt and oil doesn't clog pores when you sleep. The same goes for towels, or anything else that might come in direct contact with your face for an extended period of time.
- You may restart your regular skin care products and Retin-A once your skin is no longer irritated.
- Many clients will see continued skin improvement for months following the last treatment.
- For best results, we recommend follow up and repeat treatments in 4-6 weeks and a series of 3-5 treatments depending on your personalized care plan.

If you have any questions or concerns about anything whatsoever, please feel free to contact us so we can assist you.

RF MICRONEEDLING

PHOTO & VIDEO RELEASE FORM

I, _____ , hereby give permission for any photos, videos, or audio that are taken of me to be used in and/or for any lawful promotional materials, such as but not limited to newsletters, flyers, posters, brochures, advertisements, press kits, websites, social media pages, and other print and digital communications.

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

I renounce all claims I may have to royalties or other forms of payment resulting from or connected to the use of the image or sound recording.

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

All claims that I, my heirs, representatives, executors, administrators or any other person acting on my behalf or on behalf of my estate may hold them harmless and release them from any claims that they may bring.

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

_____	_____	_____
CLIENT NAME (PRINTED):	CLIENT NAME (SIGNATURE):	DATE:
_____	_____	_____
TECHNICIAN NAME (PRINTED):	TECHNICIAN SIGNATURE:	DATE:

RF MICRONEEDLING

TREATMENT RECORD

Full name: _____ Date of birth: _____

Phone: _____ Email: _____

TREATMENT	PRODUCTS USED	NOTES	PRICE	DATE

RF MICRONEEDLING

CANCELATION POLICY

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

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

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

Time had specifically been reserved for your appointment. 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 forfeit your deposit.

If you arrive more than 15 minutes for your appointment it is considered a no-show and your deposit will be forfeited.

We are happy to discuss any questions regarding this cancelation policy.

By signing below, I hereby acknowledge that I have completely read and fully understand the above Cancelation Policy. I agree to pay the cancelation fee in the event of a missed appointment.

_____	_____	_____
CLIENT NAME (PRINTED):	CLIENT NAME (SIGNATURE):	DATE: