Waxing Consent

Prior to receiving treatment, I have been candid in revealing any condition that may have bearing on this procedure, suc h as: recent facial surgery, mircrodermabrasion treatments and/or chemical peels, unresolved irritations of the skin, allergies, tendency to cold sores/fever blisters, and use of acne medication including Retin-A, Accutane, Differin, Tazorac, Avage or the like.

I understand that to avoid any complications I must discontinue the use of any acne or other topical medications 7 days prior to waxing and if I am on Accutane I must wait 6 months before any waxing.

I understand that the use of antibiotics could cause unusual sensitivity when waxing and that it is best to refrain fro m waxing while on antibiotics.

I understand that if I am prone to cold sores or fever blisters that waxing could cause an outbreak and I am advised against waxing or recommended to contact my physician to receive anti-viral medication to start 2 days before waxing and continue 5 days after to prevent outbreaks. I further understand that if I am currently experiencing an outbreak I should not et waxing done at all and I am responsible to inform the esthetician here if that is the case.

I agree to refrain from tanning whether outside or in tanning booths 24 hours before and after waxing.

I hereby agree to all the above and agree to have this treatment performed on me. I further agree that I have taken the necessary precautions that none of these contraindications to waxing applies to me. I understand there is a payment required for service, and this has been explained to me. I understand the procedure and accept the risks. I hereby release authorized technician performing treatment from all liabilities associated with the above indicated procedure.

I release my practitioner, medical staff, and specific technicians from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

BY SIGNING BELOW, I ACKNOWLEDGE AND CERTIFY THAT I, HAVE READ AND UNDERSTAND THE "CONSENT, RELEASE AND INDEMNITY AGREEMENT" FOR THIS PROCEDURE, AND THAT I AM SIGNING IT VOLUNTARILY.

PLEASE SIGN YOUR FULL NAME BELOW IF YOU AGREE

Patient Signature

Date