SKINCARE CORRECTIVES
where health and beauty unite
250-514-9282
skincarecorrectives.ca
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Facial Infusion Consent
Revitapen
Skincare Correctives

CLIENT NAME: _____DATE:_____

PLEASE INITIAL:

_____ I agree that the nature and purpose of the treatment has been explained to me and any questions I have regarding the treatment have been explained to my satisfaction.

_____ I understand that with any treatment certain risks are involved and that any complications from known or unknown causes could occur.

_____ I understand that possible side effects include, but are not limited to: mild to moderate redness, mild to moderate peeling or flaking, stinging, dry skin, tenderness, pimples, cold sores or allergic reactions. Most side effects are temporary and will dissipate within 3-7 days.

_____ I do not have active cold sores.

_____ I will call to inform Skincare Correctives of any complications or concerns I may have as soon as they occur.

_____ I understand that it is recommended prior to having a facial infusion to not have used Retin A for 72 hours, Accutane in 6 months or have waxed 24 hours prior to receiving treatment.

I hereby have provided accurate information, I have had the risks explained to me, and I freely consent to the Facial Infusion Treatment, accepting all risk..

_____

CLIENT SIGNATURE PRINT NAME DATE

TECHNICIAN NOTES:

Treatment Receiving Today (check one):

☐ Medi-Facial ☐ Holistic Calming Facial ☐ Other

☐ Facial Infusion ☐ Holistic Stimulating Facial _____

☐ Medi-Infusion ☐ RevitaPen Pro Facial _____

Notes: