



# Hydrofacial Consent Skincare Correctives

My signature below acknowledges that I have read the following and agree to receive treatments or series of treatments listed below.

I hereby consent to, and authorize Zoe Quindazzi of Skincare Correctives to perform Ultrasonic Hydrofacial skin treatments and MicroAMPS treatments on me.

Areas to be treated are my face, neck and \_\_\_\_\_.

The nature and purpose of the treatments have been explained to me, and any questions I have regarding this procedure have been explained to my satisfaction. I assume all potential risks.

I understand that with any treatment certain risks are involved and that any complications or side effects, from known or unknown causes could occur. I freely assume these risks.

Possible side effects include, but are not limited to: Mild or moderate redness, mild breakout, stinging, tenderness, dry skin, flaking, lightening or darkening of the skin. Most side effects are temporary and generally subside within 72 hours.

I have been advised to discontinue all Retin-A, for at least 3 days prior to treatment and 7 days after . I understand that I must use hydrating and soothing skincare for healing. Also, I understand and agree to use a broad-spectrum sunscreen of at least an SPF 15 at all times during and after treatment.

I have been advised to avoid Botox or Filler injections for up to 10-14 days before any Hydrofacial treatment and 7 days after, and I agree to these restrictions.

I agree to adhere to all safety precautions and home skin care program as recommended by Skincare Correctives

I am over 18 years of age or I have parental consent co-signed below.

I do not have a pacemaker.

I will call to inform my practitioner of any complications or concerns if they should occur.

Please Initial

\_\_\_\_ I am not pregnant

\_\_\_\_ I agree to follow the advised home care protocol

\_\_\_\_ I agree to avoid sun exposure for 48 hours

\_\_\_\_ I agree to notify Skincare Correctives of concerns

\_\_\_\_ I have not used Retin-A for 72 hours

\_\_\_\_ I agree to not wax for 72 hours, before and after

\_\_\_\_ I agree to apply sun protection daily

\_\_\_\_ I agree to remove the facial jewelry I can

\_\_\_\_ I have not taken Accutane in the past year

\_\_\_\_ I agree to avoid any Botox and Fillers for 14 days.

\_\_\_\_ I do not have a pacemaker

Client Signature: \_\_\_\_\_ Print Name \_\_\_\_\_ Date \_\_\_\_\_

Parental Signature: \_\_\_\_\_ Date: \_\_\_\_\_