CONSENT FORM FOR FACIAL SKIN TREATMENT USING PHILINGS TECHNIQUE

BETWEEN:

Practitioner/Technician	
Address	
City	
Country	

&

Client	
Address	
City	
Country	

1. STATEMENT

Client will be informed in detail about the facial skin treatment using PhiLings technique by a Practitioner.

Practitioner/Technician is obligated to perform treatment in strict compliance with all hygiene and health protection measures.

2. CLIENT HEALTH CONDITION QUESTIONNAIRE

In order to perform the facial skin treatment in a safe manner, please answer the following health questions truthfully.

This information is confidential and it shall also be handled in that way. It will not be shared with any third party.

Do you suffer from any blood disorder (thrombosis, hemophilia, anemia etc)?	YES	NO
Do you have a diabetes (type 1 or 2)?	YES	NO
Do you have any type of hepatitis (A, B, C, D, E, F)?	YES	NO
Are you HIV+?	YES	NO
Do you suffer from any skin condition (rosacea, impetigo, erysipelas, lupus, scleroderma or any other disease)?	YES	NO
Do you have a history of skin sensitivity (eczema or atopic dermatitis)?	YES	NO
Do you have allergy to medications, food, metals, makeup or any other compound?	YES	NO
Do you have any autoimmune disorder?	YES	NO
Do you suffer from any acute or chronic infectious disease?	YES	NO
Are you prone to cold sores (herpes) or fever blisters?	YES	NO
Do you have epilepsy or any other seizure-related condition?	YES	NO
Do you have any heart-related problems?	YES	NO
Are you pregnant?	YES	NO
Are you breastfeeding?	YES	NO
Do you take any prescribed medications on daily basis (e.g. aspirin, anticoagulants etc.)?	YES	NO
Are you wearing a pacemaker?	YES	NO
Do you have any problems healing from wounds?	YES	NO
Do you tend to develop keloid or hypertrophic scars?	YES	NO
Have you consumed drugs or alcohol in the past 24 hours?	YES	NO
Did you undergo surgery or any other medical procedures in the last 14 days?	YES	NO
Have you had a botox injection within 6 months?	YES	NO
Have you had a laser or chemical peels within 6 months?	YES	NO
Have you ever had PMU or any cosmetic treatment?	YES	NO
Do you routinely use Retinol-A, glycol or other exfoliating products?	YES	NO
Do you wear contact lenses?	YES	NO
Is your skin oily?	YES	NO
Do you have your period at the moment of treatment?	YES	NO
Do you have tendency to develop dark spots on the skin from wounds or sun?	YES	NO
Do you scar easily from minor skin injuries?	YES	NO
Do you bleed excessively from minor cuts?	YES	NO
Do you have prosthetic implants?	YES	NO
If you had PMU or any other cosmetic treatment did you have any problems with healing after they were applied?	YES	NO
Do you personally have any history of cancer?	YES	NO
Are you currently undergoing radiation or chemotherapy treatment?	YES	NO
Are you now or have you ever been on the acne treatment Accutane?	YES	NO
Do you have any medical condition that has resulted in a medical professional requiring you to pre-medicate with an antibiotic prior to a dental or other invasive procedure?	YES	NO

If you answered "YES" to any questions above, use the space below or separate paper to provide an explanation. Correlate your explanation to a specific question number. A "YES" answer does not indicate you are not an acceptable candidate for cosmetic procedure. It may simply be information that is valuable to Practitioner/Technician as each person's body is unique or it may indicate that based on any health condition that affect healing, it would be advisable or required for you to

CONSULT WITH YOUR PHYSICIAN BEFORE PROCEEDING. **IF THIS FORM HAS NOT REFERRED A MEDICAL CONDITION YOU HAVE PLEASE LIST IT BELOW.**

_____
_____
_____
_____
_____
_____
_____

3. CONTRACTUAL OBLIGATIONS

I AGREE ON PHOTO TAKING OF MY FACE AND USING THE PHOTOS FOR ADVERTISING PURPOSES.

YES	NO

(PLEASE CIRCLE)

4. WARRANTY

THE CLIENT HEREBY RELEASE ANY AND ALL PERSONS REPRESENTING THE SALON FOR ALL CLAIMS, DEMANDS, DAMAGES, ACTIONS AND CAUSE OF ACTION ARISING OUT OF PERFORMANCE OF THE SERVICES.

PRACTITIONER/TECHNICIAN ACCEPTS LIABILITY IN COMPLIANCE WITH THE LEGAL MEASURES AND REGULATIONS IN THE CASE OF NEGLIGENCE OR CARELESSNESS OR INTENTIONALLY OR NEGLIGENTLY CAUSED INJURIES OR THREAT TO LIFE, BODY AND HEALTH.

5. EXPLANATION

THE CLIENT IS INFORMED IN DETAIL ABOUT SPECIFIC RISKS OF FACIAL SKIN TREATMENT USING PHILINGS TECHNIQUE.

THE FOLLOWING RISKS ARE SPECIFICALLY EXPLAINED TO THE CLIENT:

- DURING THE TREATMENT, DESPITE THE STAFF EXPERTISE AND ALL THE PRECAUTIONARY MEASURES, THE INJURY IS POSSIBLE.
- DESPITE THE APPLICATION OF THE MOST ADVANCED AND THE TOP QUALITY PRODUCTS, ALLERGIC REACTION IS POSSIBLE BUT RARE. THE CLIENT IS INFORMED ABOUT THIS AND HE/SHE ASSUMES LIABILITY.
- DURING AND AFTER THE TREATMENT TEMPORARY SWELLING, REDNESS AND/OR ITCHING MAY OCCUR. EXPERIENCE TELLS US THAT THESE SYMPTOMS ARE TEMPORARY.

MICRONEEDLING

After the procedure, the skin will be red and flushed in a similar way to moderate sunburn. You may also experience skin tightness and mild sensitivity to touch on the area being treated. These effects will diminish greatly a few hours following treatment and within the next 24 hours the skin will be completely healed. After 3 days most visible erythema will be absolved.

The results of applied treatment can be different due to differences in the skin quality,
thus there is no warranty for the treatment success.

To achieve desired results, it usually takes up to 3 treatments, with 2 weeks gap between each of them. The results last from 4 to 6 months.

PHI-ION

Clusters of yellowish spots up to 0.2 mm in diameter will appear in the treated area and remain visible up to 5 days. Eye lids may get swollen and become red after the treatment and the client may feel tingling. All these side effects should disappear within 7 to 10 days.
Proper aftercare product application is of great importance.

One treatment is usually enough to achieve the desired results. After 1 month, on check-up appointment, the practitioner/technician determines if an additional treatment is necessary. The results are expected to last for at least 9 months.

Micro needling as well as plasma therapy always leads to the skin injury. Therefore, it is important to carefully and gently nurture your skin after the treatment to allow healing without complications.

Inadequate after care procedure in healing phase of the skin can lead to poor results and Practitioner and all persons representing the salon cannot be liable for it.

IN THE NEXT 7 DAYS THE CLIENT IS REQUIRED TO PAY ATTENTION TO THE FOLLOWING:

- Do not wash your face at least 5 hours, optimally 12 hours, after the treatment to ensure optimal effect of PhiFace After Treatment Mask. Within

the next 3 days after the treatment, a special kind of after care products (PhiSoothing Cream and Ultimate Skin Coctail) to be applied according to detailed instructions for use. Please do not use any other creams except the ones provided to you in order to prevent possible infections or allergic reactions.

- Do not apply makeup on the facial skin including eye lids for 48 hours after the treatment.
- In the first week after the treatment avoid public bathing, sunbathing, tanning salon, sauna, beauty treatments and intense training accompanied by sweating (sport activities), contact with the dust (household chores, etc.).
- Two weeks after the treatment do not use botox as well as dermal fillers. PhiLings palette treatments can be safely performed 3 weeks after the treatment with botox or implantation of dermal fillers.

Practitioner and all other persons representing the salon cannot be liable in case of improper post-treatment care.

6. COMPETENCE

I confirm that I have read and understood the contents of each paragraph above. I have received no unrealistic warranties or guarantees with respect to the benefits to be realized from, or consequences of, the aforementioned procedures.

YES	NO

(please circle)

I acknowledge by signing this consent form, I have been given the full opportunity to ask any and all questions about procedures and process from the Practitioner/Technician and/or his/her associates. I received a clear and understandable response to all of my questions.

YES	NO

(please circle)

The treatment procedure and post-treatment care was explained to me in detail and I understand it and agree with it.

YES	NO

(please circle)

Client's signature:_____

I personally reviewed the above information with my client.

Practitioner's signature:

_____

Date: _____ Place_____

The consent is valid without stamp and signature.

BY