

La Piele Spa
198 New York Ave Huntington, NY 11743
631-629-4334

Consent Agreement

I acknowledge that the practice of skin care including chemical peels, microdermabrasion, facials, waxing, LED light therapy, & oxygen infusion treatments are cosmetic procedures and are not an exact science. I understand that some clients experience more improvement than others. I understand that multiple treatments may be necessary to achieve the desired result. I also understand that my esthetician will provide home care instructions, and it is important to follow the estheticians instructions for optimal results as well as for safety purposes.

I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the provider updated as to any changes in my medical profile and understand that there shall be no liability to La Piele Spa should I fail to do so. I agree to release liability from La Piele Spa as well as any other officers, employees, or independent contractors known or unknown that may arise as a consequence of any treatment I receive.

By my signature below, I hereby authorize a NYS licensed Aesthetician here at La Piele Spa to administer facial treatment techniques to my child as they deem necessary

Signature: _____ Date: _____

I consent to have services performed by La Piele Spa, LTD as an elective cosmetic treatment.

Signature: _____ Date: _____

- FOR MINORS ONLY (under the age of 18)

By my signature below, I hereby authorize a NYS licensed Aesthetician here at La Piele Spa to administer facial treatment techniques to my child as they deem necessary

Signature: _____ Date: _____

LA PIELE SPA
Confidential Patient Profile

Date _____
Name _____ DOB _____ Age _____ Sex _____
Address _____
City _____ State _____ Zip _____ Phone _____
E-Mail _____ how do you hear about LA PIELE? _____
Are you pregnant or nursing? _____
Are you allergic to LATEX? ___ apples ___ citrus ___ grapes, ___ aspirin, ___ ,
hydroquinone ___ , mushrooms ___ , nuts ___ , strawberries ___
If any other allergies, what ? _____

Please list any health conditions you have or have had _____
List oral medications including birth control _____
List topical medication if applies _____
Have you ever been treated for a skin condition? _____
If yes, please list condition treated & treatment _____
Do you use sunscreen & how frequently? _____
Any history or currently have ___ eczema ___ dermatitis ___ psoriasis ___ keloid scarring ___
Do you get cold sores or fever blisters on lips or face? _____
Do you burn or tan due to sun exposure? _____ Wear sunscreen? Please list: _____
Within the last 6 weeks, please check if you have applied the following to your skin or taken orally:
___ Retin-A(retinol) ___ Glycolic/Salicylic Acid ___ Skin Lightener ___ Benzoyl Peroxide ___ Accutane ___ Antibiotic
___ Differen, or any other prescription topical medication: Please List: _____

Have you undergone cosmetic surgery? Botox? Restylane? Please list which & when:

Are you a smoker? ___ What is your alcohol consumption? ___ Glasses of water/ day? _____
Do you participate in vigorous activity or sports? exercise? _____ *certain peels require no activity for 2 days
What is your stress level? ___ Do you consume spicy foods? ___ Do you go to tanning beds or sunbathe regularly?
Are you prone to hyper pigmentation? ___ Keloid scarring _____ Anemia ___
Please check Y (yes) or N (no): ___ High Blood Pressure ___ Cancer ___ Diabetes ___ Hemophilia ___ Lupus ___ Hepatitis
___ Hormonal Imbalances ___ IBS (irritable bowel) ___ Constipation ___ Acid Reflux
What specific areas do you want to treat? Face ___ Chest ___ Hands ___ Other: _____
What type of cleanser do you use? Soap / Gel/ Milky Does your skin feel TIGHT after you cleanse? _____
Please list all other products used daily:

Please circle, which you feel, describes your skin:

Oily Tight/Dehydrated Combination Dry/Flaky Acne/Blemished Blackheads Whiteheads
Broken Capillaries Ruddy & Red Sun-damaged Uneven Tone Dull/Devitalized, Lackluster
Rough Texture Scarring Large Pores Sensitive Highly Allergic

Would you like to start a regular facial program? _____ would you like product recommendations? _____
What is your goal of TODAY'S treatment? _____ Have you ever had a facial? _____
Please list the changes you would like to see in your skin _____

We offer SPRAY TAN, CHEMICAL PEELS, MICRODERMABRASION, FACIALS, WAXING,
MAKEUP ARTISTRY, BROW SHAPING, HOT TOWEL FOOT TREATMENT,
ANTI-AGING HAND TREATMENTS, BODY PEELS, BACK FACIALS, MAKEUP LESSONS
*Please circle the services you are interested in

would you like to receive promotions & discounts? _____ via email or mail? _____
FIND US ON FACEBOOK REFER A FRIEND AND RECEIVE \$10 VOUCHER towards a service

If I experience any pain or discomfort during the session, I will immediately inform the esthetician so that the products and / or technique may be adjusted to my level of comfort. I further understand that facial should not be construed as a substitute for medical examination, diagnosis, or treatment. I understand that estheticians are not qualified to perform, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because certain treatments should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the esthetician updated as to any changes in my medical profile during the session and understand that there shall be no liability on the estheticians part should I fail to do so. I also understand that the Licensed Esthetician reserves the right to refuse to perform treatments on anyone whom he / she deems to have a condition for which facial treatments are contraindicated. I am aware that esthetic services are cosmetic & elective, and take full responsibility if I agree to have a service. I understand that cosmetic services is not a replacement for cosmetic surgery, and multiple treatments may be necessary to achieve the desired effect. I agree to follow the esthetician's pre & post protocol for more advanced skin care treatments, and do acknowledge that if I fail to do so, complications may occur, and results may not be optimal.

Client's Name (please print) _____

Client Signature _____

Date _____ NAME: _____

ESTHETICIAN'S NAME: _____

WITNESS: _____