ZEMITS FACIAL TREATMENT

CONSENT FORM

Patient Name _____

The Zemits Facial is a non-invasive treatment. Ituses different applicators to draw in skin tissueto clean the pores, deliver active serums to skin, toperform gentle massage, to deliver controlled cooling and heating at the surface of the skin.

Please read and initial each statement.

I have read the Zemits Facial Treatment Informationand Instructions and have had an opportunity to ask questions about the proceduresand treatment. _____

The Zemits Facial Treatment cost has been discussedwith me and I agree to pay this amount. _____

I duly authorize _____ to performZemits Facial Treatment on me.

I understand that:

- The goal of Zemits Facial is to hydrate and deep cleansefacial skin, to massage and stimulate the blood and lymph circulation, thatimproves the skin tones and texture, acne breakouts and general skin health.
- Every person is unique and skin condition and resultsmay vary, so it is very difficult to guarantee a specific number of treatmentsneeded. Results vary with the individual and in the case of acne and sun damagedepend on the amount of acne and compliance with recommended adjunctive measuresand skincare.
- Zemits Facial treatments are recommended every oneto two months depending on the skin type and condition for optimal results.
- Zemits Facial may be performed any time before specialevents.
- Common side effects such as slight redness usuallysubside within a few hours after treatment.
- Uncommon side effects such as bruising, skin irritationand exacerbation of skin breakout can occur.
- Very rarely, some types of allergic reactions, pigmentations,moles, skin lightening or darkening can occur and may resolve,but can be permanent.
- Scarring and textural changes are also rare side effectsbut can result from the procedure. There may be risks not yet known at thistime.
- These effects have been fully explained to me. _____(patient initials)

What to expect:

- After Zemits Facial Treatment skin may experiencetemporary irritation, redness, or tightness.
- These reactions are all normal, and may typicallyresolve within 48-72 hours depending on skin
- sensitivity.
- The following sensations may be experienced withina few hours after Marcel Facial: tingling and
- stinging in the treatment area.
- Client experiences always vary. Some patients mayexperience a delayed onset of these symptoms.
- Majority of Zemits Facial customers see the resultsimmediately after treatment and their skin may feel smooth and hydrated for few weeks with appropriatehome care to maintain treatment results.
- After Zemits Facial Treatment the skin needed tobe protected of sunburn/sun damage. All patients
- should avoid excessive sun exposure and use a minimumof SPF 40 sunscreen.

Contradictions:

These effects have been fully explained to me. _____(patient initials)

- Pacemaker or metal implants (contraindication forRF, Microcurrent)
- Recent accident or serious injury
- Recent surgical or dental procedure
- Rosacea, telangiectasia/couperose (contraindicationfor vacuum aspiration) Retin-A, Retinol (contraindication for skin exfoliation)
- Stage III or IV acne (contraindication for dermabrasion)
- Skin-lightening or bleaching agent
- Sunburn
- Swollen or infected tonsils
- Thyroid conditions (contraindication for RF, Ultrasound,Microcurrent)
- Type I diabetic (contraindication for RF, Ultrasound,Microcurrent)
- Under medical care for an existing or suspected conditionor disease
- Viral infection, influenza
- Pregnancy and breastfeeding (contraindication forRF, Ultrasound, Microcurrent)

Although every precaution will be taken to ensure your safety and wellbeing before, during and after your LED treatment, please be aware of the following information and possible risks.

Please initial:

___ I understand there are certain contraindications that would preclude me from receiving LED treatments, including epilepsy, medications causing light sensitivity, open wounds, pregnancy, and thyroid conditions.
___ I understand there are other precautions that should be considered before receiving LED therapy treatments and may require a doctor's release and/or I assume any risk involved.
___ I understand that reactions are rare, but may include nausea, dizziness, weakness, and possible skin reactions including redness and/or other irritations.
___ I understand that some clients report slight tingling sensations and flashing of the optic nerve during the procedure.
___ I understand that while the goal of this treatment is to improve the vitality of the skin, no specific guarantees of the result can or have been made.
___ I understand that it is imperative to my health that I disclose all of the information requested in the Client Profile/Health History.
___ I have cited all conditions and circumstances regarding my health history, medications being taken, and any past reactions to products or medications.
___ I understand that additional conditions could occur or be discovered during the procedure which could affect my ability to tolerate the procedure.
___ I consent to "before and after" photographs for the purpose of documentation, potential advertising and promotional purposes. I understand that if I have any concerns, I will address these with my skin care specialist.

I give permission to my skin care specialist to perform the LED procedure we have discussed, and will hold him/her and his/her staff harmless and nameless from any liability that may result from this treatment. I have accurately answered the questions above, including all known allergies, prescription drugs, conditions, or products I am currently ingesting or using topically. I understand my skin care specialist will take every precaution to minimize or eliminate negative reactions as much as possible.

In the event I may have additional questions or concerns regarding my treatment, I will consult the skin care specialist immediately. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand, the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

I understand the procedure and accept the risks. I do not hold the skin care specialist, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

Client Name (Printed) _____

Client Name (Signature) _____

Date:_____
Skin care specialist_____