**INFORMED CONSENT FOR PERFECT TOUCH TREATMENT**

**Skin imperfections removal**

I hereby authorize and direct Katherine Michelle Watson of Natural Reflections to perform perfect touch treatments on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, (client name). I have authorized the following treatment of the following areas\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I further authorize the skin care therapist to perform any other removal of those skin growths that have been approved for treatment. The details of the procedure have been explained to me in terms that I could understand. I am advised that though good results are expected, complications cannot be anticipated and that therefore there can be no guarantee, either expressed or implied, as to the results of the treatment. I understand that possible complications post treatment might include hypopigmentation (lighter skin color where growth was removed), infection if I scratch treated area before it is healed, or possible scarring if I am prone to keloids.

I consent to have the Perfect touch utilized on me for the purpose of the cosmetic treatment of skin imperfections removal as with any cosmetic procedure, the goal is for esthetic improvement not perfection. Risk associated with the treatment are minimal and may include burns/scabbing, skin discoloration and scarring, thus it is extremely important to follow home care recommendations to minimize these risks. I agree that if I am unsure of any underlying conditions (ex: skin cancer, skin disease), I will consult a physician prior to undergoing any cosmetic treatment.

In consenting to have the perfect touch performed on me, I hereby release and forever discharge the practitioner of above said cosmetic procedures, of and from all claims, demands, damages actions or cause of action arising out of the performance of the said cosmetic procedures, which I, my heirs’ executors, administrators or assigns can, shall or may have. \_\_\_\_\_ (Please initial here)

PLEASE INITIAL:

\_\_\_\_I have voluntarily and totally agree and under my own responsibility and liability to undergo this treatment/procedure after the nature and purpose of this treatment has been explained to me, along with the risks involved.

\_\_\_\_I understand that my skin needs time to heal and certain days to see results.

\_\_\_\_All what is done in this treatment on my skin, is done under my full responsibility and the operator or who did the treatment does not hold any responsibility or liability toward me, and I waive now and in the future all my rights to contest against the operator.

\_\_\_\_I understand that this treatment is not recommended for diabetics or for people with high blood pressure. I am NOT diabetic nor do I have high blood pressure.

\_\_\_\_If you have a pacemaker, are pregnant or have had a baby within the last 6 months you are not a candidate for this treatment. Clients with Fibromyalgia and Mitral Valve Prolapse will be asked to provide a release form from their physician.

\_\_\_\_The skin care therapist has answered all of my questions and has explained the MOST LIKELY complications or problems that might occur during the treatment and healing period AND I UNDERSTAND THEM.

\_\_\_\_I CERTIFY THAT I HAVE READ AND THAT I UNDERSTAND THIS CONSENT FORM AND THAT ALL BLANKS WERE FILLED IN PRIOR TO MY SIGNATURE.

\_\_\_\_I understand that before and after photos will be taken of my procedures(s) for the purpose of documentation.

CLIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CLIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHONE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SKIN CARE THERAPIST SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_