CONSENT FORM FOR RADIO FREQUENCY TREATMENT

I**,** _____ authorize Cheryl Lynn's Esthetics to perform capillary dialysis treatment for _____ on _____ (Day/Month/Year).

Areas to be treated: _____

The nature and purpose of this treatment has been explained to me, and any questions I may have regarding this procedure have been explained to my satisfaction _____(initials).

I DO NOT have any of the following conditions: Pacemaker, metallic implants, diabetes, pregnancy, or use blood thinning drugs. I understand these conditions are contraindicated with Radio Frequency treatments _____(initials).

Side effects may include mild redness, extreme redness, local swelling, bruising, tenderness, stinging, temporary darkening of the skin, infection. Most side effects are temporary and generally subside within 1 week to 21 days _____(initials).

I understand that with any treatment certain risks are involved and that complications or side effects from known or unknown causes can occur. I freely assume these risks on my own _____(initials).

I have been advised not to touch or rub treated areas, not to pick scabs, but to let any scabs fall off by themselves. I understand that I must keep area clean and use a hydrating cream to soothe area, avoid sun exposure for 1 week and use a total sun block on treated area(s) until healing is complete _____(initials).

I have received a copy of the Post-Care Instructions _____(initials).

During cold sores, inflammatory acne or other skin eruptions it is necessary to discontinue Radio Frequency treatments due to the possibility of the procedure spreading the eruption(s). The procedure should be deferred until the skin is healed _____(initials).

I agree to adhere to all safety precautions and home care as recommended by my Esthetician and I will inform Cheryl Lynn's Esthetics of any concerns or complications if they occur _____(initials).

While satisfying results are often achieved from 1 treatment, many cases may need up to 3 treatment and will be charged consecutively. Knowing that results desired are not always the results achieved _____(initials).

My signature below and my initials at each paragraph acknowledge that I have read the preceding statements and give consent to the Radio Frequency Treatments.

I do _____ do not _____ give consent to the use of any before and after photographs to Cheryl Lynn's Esthetics.

Client Name _____Signature _____

Family Doctor _____

Practitioner _____