Neroli
Institute

1880Howard Ave, #203
Vienna, VA 22182
703.356.6143

HEALTH HISTORY INFORMATION FOR IPL & LASER HAIR REMOVAL

NAME: TODAY'S DATE:
LAST, FIRST M.I

HOME ADDRESS:
DATE OF BIRTH: AGE: SEX: ☐ FEMALE ☐ MALE
HOME PHONE: CELL PHONE:
EMAIL:
I consent to this email address being added to the MedSpa and will be used to send email newsletter, where I will get information on specials and promotions. ☐ YES ☐ NO
LEAVE MESSAGES AT ☐ HOME ☐ CELL ☐ EMAIL

OCCUPATION:
PRIMARY CARE PHYSICIAN | PHONE NUMBER:

IN CASE OF EMERGENCY, WHO SHOULD BE NOTIFIED? *[name and phone]*

UNLESS OTHERWISE INDICATED, WE HAVE PERMISSION TO COMMUNICATE CHANGES IN YOUR HEALTH STATUS, INCLUDING SURGERY, TO OTHER PHYSICIANS PARTICIPATING IN YOUR CARE. ☐ YES MAY NOTIFY ☐ NO, PLEASE DO NOT NOTIFY

DO YOU HAVE ANY MAJOR MEDICAL PROBLEMS, SERIOUS ILLNESS? ☐ YES ☐ NO
IF SO, PLEASE LIST:

PLEASE LIST ALL PRIOR SURGICAL PROCEDURES AND DATES PERFORMED:

PLEASE LIST ALL INJECTABLE PROCEDURES {Botox, Jevederm, Restylane, Collagen, etc.} AND DATES PERFORMED:

MEDICAL HISTORY

DO YOU HAVE A PACEMAKER OR DEFIBRILLATOR?..... ☐ YES ☐ NO

DO YOU SUFFER FROM "PHOTOSENSITIVITY" {EXTREME SENSITIVITY TO SUNLIGHT}..... ☐ YES ☐ NO

DO YOU HAVE A HISTORY OF EASY/EXCESSIVE HYPERPIGMENTATION?..... ☐ YES ☐ NO

DO YOU FORM KELOID SCARS?..... ☐ YES ☐ NO

DO YOU HAVE ANY METAL IMPLANTS?..... ☐ YES ☐ NO

DO YOU WEAR CONTACT LENSES?..... ☐ YES ☐ NO

HAVE YOU TAKEN ACCUTANE,RETIN A, OR RENOVA IN THE PAST 12MONTHS?..... ☐ YES ☐ NO

ARE YOU CURRENTLY TAKING COUMADIN [Warfarin] OR OTHER BLOOD THINNERS?. ☐ YES ☐ NO

DO YOU REQUIRE ANTIBIOTICS BEFORE PROCEDURES SUCH AS DENTAL CLEANINGS?..... ☐ YES ☐ NO

DO YOU SMOKE? ☐ YES ☐ NO IF YES, HOW MANY PACKS PER DAY?

DO YOU DRINK ALCOHOL? ☐ YES ☐ NO IF YES, QUANTITY PER WEEK?

HAVE YOU EVER HAD AN ADVERSE REACTION TO LASER OR COSMETIC TREATMENTS?

☐ YES ☐ NO IF SO, PLEASE LIST:

ARE YOU ALLERGIC TO ANY MEDICATIONS?..... ☐ YES NO
IF SO, PLEASE LIST:

DO YOU HAVE ANY OTHER ALLERGIES?..... ☐ YES NO
IF SO, PLEASE LIST:

DO YOU TAKE ANY OF THE FOLLOWING **[Please check all that apply and/or list additional medications]**:

- ☐ ANTIBIOTICS
- ☐ ANTI-COAGULANTS
- ☐ ANTI-DEPRESSANTS
- ☐ APPETITE DEPRESSANTS
- ☐ ASPIRIN OR IBUPROFEN
- ☐ BLOOD PRESSURE MEDICATION
- ☐ CORTISONE OR STEROIDS
- ☐ HORMONES/CONTRACEPTIVES
- ☐ INSULIN
- ☐ NSAIDS
- ☐ SEDATIVES
- ☐ THYROID MEDICATION
- ☐ OTHER
- ☐ OTHER

ARE YOU TAKING HERBAL PREPARATIONS OR VITAMINS [St.JohnsWort,VitaminE, etc.]?.. ☐ YES ☐ NO

ARE YOU OR MIGHT YOU BE PREGNANT?..... ☐ YES NO

ARE YOU TRYING TO BECOME PREGNANT?..... ☐ YES NO

ARE YOU NURSING?..... ☐ YES ☐ NO

HAVE YOU EVER HAD ANY PROBLEMS WITH ANY OF THE FOLLOWING ANESTHETICS?
IF SO, PLEASE SPECIFY:

- ☐ BLOCK [e.g, dental]: Ineffective|Heart palpitations|Systemicreaction|Other:
- ☐ LOCAL: Ineffective|Heart palpitations|Systemicreaction|Other:
- ☐ TOPICAL: Ineffective|Heart palpitations|Systemicreaction|Other:

HAVE YOU EVER HAD OR DO YOU HAVE ANY OF THE FOLLOWING **[Pleasecheckallthatapply]:**

- ☐ Active Infection
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Blistering Sunburns
- ☐ Circulation Problems/Blood Clots
- ☐ Cold Sores/Shingles
- ☐ Collagen Disorders
- ☐ Diabetes(Type_____)
- ☐ Easy Bruising
- ☐ Eczema
- ☐ Endocrine/Hormonal Issues
- ☐ Eye Problems
- ☐ Fatigue
- ☐ Fibromyalgia
- ☐ Headaches/Migraines
- ☐ Heart Condition
- ☐ Hepatitis
- ☐ High/Low Blood Pressure
- ☐ HIV/AIDS
- ☐ Hormonal Imbalance
- ☐ Insomnia/Sleeping Problems
- ☐ Joint Injury
- ☐ Multiple Sclerosis
- ☐ Muscle Pain/Spasms
- ☐ Neurological Disorders
- ☐ Permanent Makeup/Tattoo
- ☐ Pigmentation Disorders
- ☐ Psoriasis
- ☐ Melanoma
- ☐ Recent Surgery
- ☐ Scleroderma
- ☐ Sensitive Teeth
- ☐ Skin Cancer
- ☐ Skin Injury
- ☐ Stroke
- ☐ Unusual Moles
- ☐ Varicose Veins
- ☐ Vision Deficits
- ☐ Other

SKIN CARE HISTORY AND CONCERNS

PLEASE LIST ANY PRODUCTS THAT IRRITATE YOUR SKIN:

HAVE YOU HAD UNPROTECTED SUN EXPOSURE OR BEEN IN A TANNING BOOTH IN THE LAST 2 WEEKS? ☐ **YES** ☐ **NO**

DO YOU USE SELF TANNERS? ☐ YES ☐ NO IF YES, WHEN WAS THE LAST APPLICATION?
ARE YOU PLANNING A VACATION IN THE SUN IN THE NEXT 3-6 MONTHS? ☐ YES ☐ NO

HAVE YOU USED ANY OF THE FOLLOWING HAIR REMOVAL METHODS IN THE PAST 6 WEEKS?:
☐ **SHAVING** ☐ **WAXING** ☐ **ELECTROLYSIS** ☐ **PLUCKING/TWEEZING** ☐ **STRINGING** ☐ **DEPILATORIES**

PLEASE INDICATE YOUR CURRENT SKIN CARE PRODUCTS/REGIMEN:

THERAPIST/PROVIDER REVIEWED: SIGNATURE _____ DATE_____
THERAPIST PRINTED NAME:

EXCLUSIONARY CRITERIA FORM

☐ YES ☐ NO I have had unprotected sun exposure, used a tanning bed or applied a tanning cream in the area(s) to be treated within the six weeks prior to my first treatment on a regular basis (tanned skin will not be treated with laser). Protected sun exposure means wearing protective clothing or the daily use of an SPF-30 or greater sunscreen.

☐ YES ☐ NO I have used a mechanical form of epilation with the six weeks prior to my first treatment (this applies to laser hair removal treatments only.) Mechanical epilation includes Plucking, waxing, tweezing, electrolysis, threading, or sugaring.

☐ YES ☐ NO I have a history of seizures. Flashing lights may trigger a seizure.

☐ YES ☐ NO Medications I am taking Accutane, anticoagulants or St. John's Wort. I am taking a medication or herbal remedy that may make my skin sensitive to light (photosensitizing).

☐ YES ☐ NO I have a history of keloid and hypertrophic scar formation. Although scarring is rare, picking or pulling off scabs or crusting can result in scarring. For this reason it is recommended to exclude from treatment clients with known tendency to form keloid or hypertrophic scars. Clients with this history are evaluated on a case by case basis to determine if treatment can be performed.

☐ YES ☐ NO I have an active infections or am immunosuppressed. (Active infections and immuno-suppression compromise the healing ability of the body).

☐ YES ☐ NO I have an open lesion in the area to be treated.

☐ YES ☐ NO I have a history of Herpes I or II within the area to be treated.

☐ YES ☐ NO I am using or have used within the two weeks prior to treatment Tretinoin (Retin-A, Renova) or a retinol product in the area to be treated.

PLEASE NOTE A "YES" TO ANY OF THE ABOVE MAY EXCLUDE CLIENT FROM THE LIGHT THERAPY (LASER/IPL) TREATMENTS.

PRINT CLIENT NAME:

SIGNATURE: DATE:

WITNESS: DATE:

MY SPECIFIC CONCERNS AND INTERESTS

(Please check all that apply and indicate any prior treatments in space provided)

CONCERNS	LIST ANY PRIOR TREATMENT AND APPROXIMATE DATE(S): *[Accutane/Botox/Peels/IPL/Lasers/Surgery/etc.]*
☐ Dry or Oily Skin	
☐ Skin discoloration	
☐ Brown Spots	
☐ Acne	I have used Accutane: ☐ Yes ☐ No | Last Dose:
☐ Rosacea	
☐ Fine Wrinkles	
☐ Lip Lines	
☐ Thin Lips	
☐ Nasolabial Creases	
☐ Marionette Lines	
☐ Loose Skin	
☐ Aging Hands	
☐ Excessive Sweating	
☐ Facial/Body Hair	
☐ Scars	
☐ Facial Veins	
☐ Leg Veins	
☐ Not Certain	
☐ Toenail Fungus	
☐ CoolSculpting/Body Contouring	
☐ Other	

CLIENT SIGNATURE: DATE:

PRINTED NAME:

PROVIDER NAME AND SIGNATURE: **DATE:**

THE FITZPATRICK SKIN-TYPE CHART

You can use this skin-type chart for self-assessment, by adding up the score for each of the questions you've answered. At the end there is a scale providing a range for each of the six skin-type categories. Following the scale is an explanation of each of the skin types. You can quickly and easily determine which skin type you are.

GENETIC DISPOSITION

SCORE	0	1	2	3	4
What is the colour of your eyes?	Light blue, Grey, Green ☐	Blue, Grey, or Green ☐	Blue ☐	Dark Brown ☐	Brownish Black ☐
What is the natural colour of your hair?	Sandy Red ☐	Blond ☐	Chestnut/ Dark Blond ☐	Dark Brown ☐	Black ☐
What is the colour of your skin (non exposed areas?)	Reddish ☐	Very Pale ☐	Pale with Beige tint ☐	Light Brown ☐	Dark Brown ☐
Do you have freckles on unexposed areas?	Many ☐	Several ☐	Few ☐	Incidental ☐	none ☐

TOTAL SCORE FOR GENETIC DISPOSITION: _____

REACTION TO EXPOSURE

SCORE	0	1	2	3	4
What happens when you stay in the sun too long?	Painful redness, blistering, peeling ☐	Blistering followed by peeling ☐	Burns sometimes followed by peeling ☐	Rare burns ☐	Never had burns ☐
To what degree do you turn brown?	Hardly or not at all ☐	Light colour tan ☐	Reasonable tan ☐	Tan very easy ☐	Turn dark brown quickly ☐
Do you turn brown within several hours after sun exposure?	Never ☐	Seldom ☐	Sometimes ☐	Often ☐	Always ☐
Do you have freckles on unexposed areas?	Very Sensitive ☐	Sensitive ☐	Normal ☐	Very Resistant ☐	Never had a problem ☐

TOTAL SCORE FOR REACTION TO SUN EXPOSURE: _____

TANNING HABITS

SCORE	0	1	2	3	4
When did you last expose your body to sun [or artificial sun lamp/tanning cream?]	More than 3 months ago ☐	2–3months ago ☐	1–2months ago ☐	Less than a month ago ☐	Less than 2 weeks ago ☐
Did you expose the area to be treated to the sun?	Never ☐	Hardly Ever ☐	Sometimes ☐	Often ☐	Always ☐

TOTAL SCORE FOR TANNING HABITS: _____

***Add up the total scores for each of the three sections for your* **Skin Type Score**.

SKIN TYPE SCORE –FITZPATRICK SKIN TYPE

0–7	1
8–16	II
17–25	III
25–30	IV
OVER 30	V–VI

☐ **TYPE 1**:Highly sensitive, always burns, never tans.
Example: Red hair with freckles.

☐ **TYPE 2**: Very sun sensitive, burns easily, tans minimally.
Example: Fair skinned, fair haired Caucasians.

☐ **TYPE 3**: Sun sensitive skin, sometimes burns, slowly tans to light brown.
Example: Darker Caucasians.

☐ **TYPE 4**: Minimally sun sensitive, burns minimally, always tans to moderate brown.
Example: Mediterranean type caucasians, some hispanics.

☐ **TYPE 5**: Sun insensitive skin, rarely burns, tans well.
Example: Some Hispanics, some Blacks.

☐ **TYPE 6**: Sun insensitive, never burns, deeply pigmented.
Example: Darker Blacks.

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INFORMED CONSENT FORM IPL and LASER HAIR REMOVAL

CLIENT NAME: DATE:
TREATMENT SITES:

I DULY AUTHORIZE NEROLI MEDSPA'STECHNICIANS TO PERFORM _____
_____TREATMENT.

I UNDERSTAND THAT CLINICAL RESULTS MAY VARY DEPENDING IN INDIVIDUAL FACTORS,INCLUDING BUT NOT LIMITED TO MEDICAL HISTORY, SKIN TYPE, PATIENT COMPLIANCE WITH PRE AND POST TREATMENT INSTRUCTIONS, AND INDIVIDUAL RESPONSE TO TREATMENT. **INITIALS** _____

I UNDERSTAND THAT THERE IS A POSSIBILITY OF SHORT TERM EFFECTS SUCH AS REDDENING, MILD BURNING, TEMPORARY BRUISING AND TEMPORARY DISCOLORATION OF THE SKIN, AS WELL AS THE POSSIBILITY OF RARE SIDE EFFECTS SUCH AS SCARRING AND PERMANENT DISCOLORATION. THESE EFFECTS HAVE BEEN FULLY EXPLAINED TO ME
INITIALS _____

I UNDERSTAND THAT TREATMENT WITH THE _____INVOLVES A SERIESOF TREATMENTS AND THE FEE STRUCTURE HAS BEEN FULLY EXPLAINED TO ME
INITIALS _____

I CERTIFY THAT I HAVE BEEN FULLY INFORMED OF THE NATURE AND PURPOSE OF THE PROCEDURE, EXPECTED OUTCOMES AND POSSIBLE COMPLICATIONS, AND I UNDERSTAND THAT NO GUARANTEE CAN BE GIVEN AS TO THE FINAL RESULT OBTAINED. I AM FULLY AWARE THAT MY CONDITION IS OF COSMETIC CONCERN AND THAT THE DECISION TO PROCEED IS BASED SOLELY ON MY EXPRESSED DESIRE TO DO SO.
INITIALS _____

I CONFIRM THAT I HAVE INFORMED THE STAFF REGARDING ANY CURRENT OR PAST MEDICAL CONDITION, DISEASE OR MEDICATION TAKEN. **INITIALS** _____

I CONSENT TO THE TAKING OF PHOTOGRAPHS AND AUTHORIZE THEIR ANONYMOUS USE FRE THE PURPOSE OF MEDICAL AUDIT, EDUCATION AND PROMOTION.
INITIALS _____
I CERTIFY THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS AND THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS CONSENT FORM.
INITIAL _____

CLIENT SIGNATURE:

DATE

Laser Hair Removal Informed Consent Form

1. Informed Consent

The purpose of this Informed Consent is to help you decide whether a laser hair removal ("LHR") cosmetic procedure is right for you and to help you make an informed decision to undergo this procedure. This Informed Consent gives you general information about LHR cosmetic procedures, explains other treatment options, and identifies the benefits, risks, side effects and possible complications associated with LHR procedure

2. Laser Hair Removal Procedure

LHR is a non-invasive laser treatment designed to remove unwanted hair from all parts of the body. The laser device works by emitting pulses of light energy that penetrate the skin and destroy hair follicles while the device's hand piece cools the surrounding skin. Because the laser needs to fill the hair follicle to work effectively, it is important not to wax, tweeze, have electrolysis procedures or pluck hair for 2-4 weeks prior to the procedure.

You will be required to wear protective eye glasses during the procedure to protect your eyes from the laser light. You may feel a slight burning, stinging or pinching sensation during the procedure. It generally takes 10 to 21 days after the procedure for the treated hair to fall out. Treatment of dark course hair generally achieves the best results while removal of light fine hair generally requires additional treatments which may or may not be successful. Clinical results of LHR may also vary depending on individual skin type, hormonal levels and hereditary influences. Therefore, some patients may experience partial results and some may notice no improvement at all. Future hormonal changes may cause additional hair growth. LHR procedure generally involves a series of treatments. Ideal (light skin/dark hair) candidates can usually achieve 65%-90% reduction with a series of 6 treatments. Thicker skinned areas such as men's backs, faces or neck usually require more than 6 sessions and usually achieve only partial reduction or hair thinning.

3. Alternative Procedures

LHR is a voluntary cosmetic procedure which is not necessary or required. Not doing the procedure is an option.

4. Not Good/No Candidates

Generally you are not a good candidate for LHR procedure if you are pregnant, nursing or plan to become pregnant while undergoing LHR treatments. Individuals who have used Accutane within the past six months or who used any medications requiring limited exposure to sunlight are not good candidates for LHR procedure. Individuals with recently tanned skin are advised to delay undergoing the LHR procedure. The laser may not be effective on blond or gray hair.

Sun exposure 2-4 weeks prior to treatment may reduce effectiveness of the laser. It is important to shave the area prior to treatment session. (we do not provide shaving services as you must do this yourself prior to the treatment). Please inform us if you have an allergy to Aloe.

5. Risks and Complications

All medical and cosmetic procedures are associated with certain risks and may result in complications. Some but not all of the possible risks and complications associated with LHR procedure include:

- Temporary reddening, burning, swelling, bruising or discoloration of the skin over the treated area.
- Blistering, scarring, activation of cold sores, infection or permanent discoloration, which may occur in rare cases. Please inform us if you have ever had a problem with cold sores.
- Folliculitis, which is an infection of the hair follicle, which may take several days to resolve
- Hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin), which rare may take several months to fully resolve
- Crusting or blistering of the area exposed to laser, which is rare and which may take several days to heal.
- As with all LHR procedures, some re-growth of hair may occur after treatment sessions are completed.

6. Post Procedure Instructions

It is important that you comply with all post procedure instructions. In addition, it is important that you limit sun exposure after the LHR procedure and use protective sunscreen lotion. Please call your doctor promptly if complications develop after the procedure. Laser-treated areas should not be exposed to sun or tanning beds Not

adhering to the post treatment skin care instructions may increase the risk of complications.

By signing this Informed Consent, you understand and agree as follows (Please, **read carefully** and **initial** next to each statement):

____The information contained in this Informed Consent was explained to me using terms I could understand, and all my questions and concerns have been answered. After reviewing all the information provided to me about cosmetic procedures and reviewing my health status, I believe I am a good candidate for LHR procedure.
____I understand that LHR is an elective procedure and hereby freely accept all possible risks, complications and side effects that may result from this procedure.
____This consent form is valid for all future laser hair removal treatments performed, and if I will alert the staff if there are any future changes to my medical history, or if I become pregnant
____ I am not pregnant, nursing, or trying to become pregnant.
____ I have stopped use and been off of all antibiotics, or any other drug that may cause photosensitivity, for at least 7 days.
____ I have not used Accutane or any other isotretinoin medication in the past 6 months.
____ I have not used self-tanner in the area to be treated in the past 7 days.
____ I have not received electrolysis, tweezed, waxed, threaded, or removed hair from the follicle any method other than shaving in the past 3-4 weeks.
____ I am aware if I have herpes simplex virus 1 or 2, I need to be on an oral antiviral medication at least 2-3 days prior to laser treatment.
____ Laser hair removal produces an intense burst of light and light energy to selectively heat, remove, and/or reduce hair.
____ For best results, I have been informed multiple treatments will be necessary.
____ For best results, I understand laser hair removal treatments need to be scheduled consecutively and it is recommended they are scheduled 4-6 weeks apart depending on the area being treated.
____ I understand laser hair removal is based on the principles of selective photothermolysis; and, it is a combination of the appropriate laser wavelength, pulse duration, and fluence. Not all laser hair removal devices use the same wavelengths, pulses, and/or fluence.
____ I understand that all lasers and/or laser hair removal devices are not the same and, if I have had laser hair removal treatments somewhere else or do so in the future, the laser treatment I received may not be the same as the laser treatment I will receive at Optimaderma.
____ I understand complete removal and/or clearing of my hair may not be possible.
____ I understand maintenance may be needed after my initial series of treatments; and, new hair growth may occur in the treated area. This new hair growth may be caused by various factors including age, hormones, and/or new medications.
____ I understand the risks and complications that may be associated with this procedure. I have been informed about the risks and complications may include, but are not limited to:

- Bruising and purpura (red-purple discoloration)
- Bleeding
- Infection
- Hyperpigmentation (darkening of the skin) and may be permanent
- Hypopigmentation (lightening of the skin) and may be permanent
- Itching or a hive-like response
- Burns, blisters, textural changing or scarring
- Swelling, redness and/or discomfort

____ I am aware this procedure may activate individual sensitivities. These sensitivities may include, but are not limited to:
Herpes simplex virus, which can cause cold sores and fever blisters, hirsutism (increased hair growth), an/or Lymphadenopathy (enlarged lymph nodes).
____ After laser treatment, redness, swelling, welting, itching, dry skin and/or discomfort may occur. I understand these complications typically resolve within a few hours, days, weeks, or months; however, some complications such as scarring, hyperpigmentation, and/or hypopigmentation may be permanent.
____ I understand any redness, swelling, and/or discomfort usually resolves within several hours, but may last for 2-3 days. The treated area may feel like a sunburn or windburn (minor discomfort) for a few hours after treatment. Discomfort may be treated with the application of cool compresses, antibiotic ointment, Aquaphor, and/or topical soothing agents.
____ I am aware I will be given aftercare instructions regarding care of the treated area(s). I understand it is important to follow all aftercare instructions carefully to minimize the risks of incomplete healing, scarring, and/or skin textural changes.
____ I am aware that there are other methods of treatment available for hair removal and have assessed the risks and benefits of laser hair removal and these alternative methods.
____ Anesthesia is usually not necessary for this procedure. My provider and I may elect to use a form of anesthesia to reduce my discomfort during the procedure. A cryogen spray skin cooling device may be used during the procedure to decrease discomfort and protect the skin.
____ I understand I need to avoid direct sunlight, because sun sensitivity of the treated area may remain for several weeks after a laser treatment.
____ I understand I need to protect my skin from the sun and I need to use a broad spectrum UVA/UVB protective sunscreen in order to reduce the risk of damage to the skin. I understand I must wear a broad spectrum UVA/UVB protective sunscreen during instances where I am exposed to sunlight. These instances include, but are not limited to:

- sitting in the car
- walking to the mailbox
- sitting next to a window to reduce the risk of damage to the skin.

____ I understand my skin may be sensitive for a week or more after laser treatment and I should avoid using extremely hot water and skin care products that may cause irritation. These skin care products may include, but are not limited to: scrubs, toners, retinoids, glycolic acids, anti-aging ingredients, and/or acne products.

____ I understand hair growth occurs in three different cycles which are explained to me clearly and the hair must be in the Anagen phase of growth in order for laser hair removal to work. The duration of hair cycle and percentage of hair in the Anagen (growth) phase is different for all areas of the body. I also understand the depth of the hair follicle varies throughout the body. Age, ethnicity, metabolism, medications, and changes in hormones affect the location, resilience, and thickness of hair. I understand these factors influence the success of laser treatments, why multiple treatments are needed and, why we are unable to predict the number of treatments each individual will need to be satisfied with the results.

____ I understand laser hair removal is a cosmetic procedure that is elective and is not covered by insurance.

____ I understand, recognize, and acknowledge the physicians, practitioners, delegated staff/IMG, assistants, and specific technicians and the facility, its affiliates, officers, directors and/or representatives have made no guarantees to me concerning the results of my laser treatments.

____ I have provided my past and current medical history and medications.

____ Contraindications of this procedure have been discussed in detail with me.

____ I have read and understand all information presented to me concerning this procedure before signing this consent form.

____ Questions I have about the risks, benefits, and results pertaining to this procedure have been answered and discussed to my satisfaction.

____ I hereby commit myself not to leave any comments or information in any social media or elsewhere, or communicate, with any entity, any such comments or information that may damage the reputation of NEROLI in any form or extent whatsoever, and will only share any such comments and feedback with NEROLI.

____ I understand that my commitments, consent and other contents stated in the present document shall survive after the completion of the services or even I elect to stop receiving the services at any stage thereof.

I hereby release the physicians, practitioners, delegated staff/IMG, assistants, and specific technicians and the facility, its affiliates, officers, directors and/or representatives from all liability, covenants, obligations, claims and sum of money arising out of or in association and connection with my procedure(s)/Treatment(s), together with any rights and causes of actions that I may have had against the physicians, practitioners, delegated staff/IMG, assistants, and specific technicians and the facility, its affiliates, officers, directors and/or representatives .This release shall be binding upon my heirs, executors, administrators and assigns, who jointly and severally with myself waive all defenses to the strict enforcement of the provisions of this release and consent. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns. I hereby give my consent to this procedure and have been asked to sign this form after my discussion and consultation with .....

Refund , Return and Cancellation Policy

As a courtesy to other Spa guests and our therapists, please give at least a 48-hour notice of cancellation to avoid a $25 charge or as a penalty one of your sessions taken away. A credit-card number , advanced payment, or gift-certification number may be required at the time of booking. For spa packages and two or more guests coming together we require a 48 - hour cancellation notice. Groups and bridal parties will require a 50% deposit at the time of booking. A refund is not available after you have used a portion of the services you booked.After one session the fee for package of two is non-refundable.Please ask new update of our staff about our refund and return and cancellation policy.Educational programs After two sessions the fee for programs is non-refundable.We do not provide refunds for cancelled or missed appointments.

CLIENT	**NEROLI**
Signature & Date	Signature & Date
Print Name	Print Name