MICRONEEDLING
Consent Form

I, ..., hereby consent to undergo a Microneedling Facial treatment at High Tide Beauty Bar, LLC. I have been fully informed about the nature of the treatment, its potential risks, benefits, and alternatives.

I understand that Microneedling Facial involves the use of fine needles to create micro-injuries in the skin, which can stimulate collagen production, improve skin texture, and reduce the appearance of fine lines, wrinkles, and scars.

I acknowledge that results may vary from person to person, and multiple sessions may be required to achieve the desired outcome.

I understand the potential risks associated with Microneedling Facial, including but not limited to:

1. Redness, swelling, and bruising in the treatment area.
2. Temporary discomfort or pain during the procedure.
3. Infection, although rare, is possible if post-care instructions are not followed.
4. Hyperpigmentation or hypopigmentation.
5. Scarring in rare cases.
6. Allergic reactions to topical products used during the treatment.

I have disclosed all relevant medical history and conditions to my practitioner and understand that it is my responsibility to provide accurate information. I also understand that it is crucial to follow post-care instructions to minimize the risk of complications.

I have had the opportunity to ask questions and have received satisfactory answers regarding the Microneedling Facial treatment. I have not been coerced or pressured into undergoing this procedure, and I consent to it willingly.

I understand that no guarantees have been made regarding the specific results of this treatment.

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Client printed Name	*Client signature*	*Date*

MICRONEEDLING
Client Intake

GENERAL INFORMATION

Name: .... Date: ....

Date of birth: .... Age: .... ◯Female ◯Male ◯NB

Address: ....

City: .... State: .... Zip: ....

Phone: .... Email: ....

MEDICAL HISTORY

Please check any of the following medical conditions that apply to you:

- ☐ Active acne or cold sores
- ☐ Skin cancer or lesions
- ☐ Rosacea or eczema
- ☐ Psoriasis
- ☐ Keloid or hypertrophic scarring
- ☐ Blood clotting disorders
- ☐ Autoimmune disorders (e.g. lupus)
- ☐ Diabetes
- ☐ Herpes simplex virus (HSV)
- ☐ Pregnancy or breastfeeding

If you checked any of the above, please give details: ....

....

Any other conditions: ....

List any medications you take regularly, including vitamins, herbal supplements aspirin:

....

Do you have any allergies? ◯Yes ◯No If yes, please specify: ....

....

Have you had any recent facial injectables or fillers? ◯Yes ◯No If yes, please specify:

....

MICRONEEDLING

Client Intake

Have you had any recent facial injectables or fillers? ☐ Yes ☐ No, If yes, please describe:

....

Have you had any recent exposure to the sun or tanning beds? ☐ Yes ☐ No, If yes, please describe: ....

Have you ever had any adverse reactions to microneedling or other cosmetic treatments? ☐Yes ☐No If Yes, please describe: ....

What brings you to seek microneedling treatment? ....

....

Have you received microneedling or other cosmetic treatments before? ☐Yes ☐No , If so, please describe your experience: ....

Do you have any concerns or preferences regarding the treatment, such as the depth of the needles used or the addition of growth factors or other serums? ....

....

Is there anything else you would like me to know about your health or well-being?

....

I understand that my personal and medical information will be kept confidential, and will only be shared with other healthcare providers or agencies as required by law or with my written consent.

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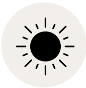
Client printed Name	*Client signature*	*Date*

MICRONEEDLING

Aftercare Advice


Avoid sun exposure and wear sunscreen with SPF 30 or higher.

Avoid swimming pools, hot tubs, saunas, and other sources of heat and moisture for at least 24-48 hours after the treatment.

Do not apply makeup or any skincare products to the treated area for at least 24 hours after the treatment.

Do not touch or scratch the treated area, as this may introduce bacteria and cause infection.

Avoid strenuous exercise and activities that cause excessive sweating for at least 24 hours after the treatment.

Use only gentle, non-irritating skincare products for the first few days after the treatment, and avoid exfoliants and acids for at least 48 hours.

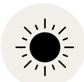
Drink plenty of water and eat a healthy diet to promote healing and nourish your skin from the inside out.

Follow up with your practitioner as recommended to monitor your progress and adjust your skincare regimen if necessary.

If you experience any unusual symptoms or reactions, such as excessive redness, swelling, or pain, or if you notice any signs of infection, such as pus or fever, contact your practitioner immediately.

MICRONEEDLING

Pre-care



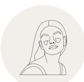
Avoid sun exposure and tanning beds for at least 2-4 weeks prior to the treatment.

Discontinue the use of any retinoids, acids, or other exfoliants at least 5-7 days before the treatment.

Avoid taking blood-thinning medications, such as aspirin or ibuprofen, for at least 48 hours before the treatment, unless otherwise directed by your physician.

Do not wax, tweeze, or use depilatory creams on the treatment area for at least 24 hours before the treatment.

Avoid using any topical products containing alcohol, fragrances, or other potentially irritating ingredients on the treatment area for at least 24 hours before the treatment.



If you have any active skin conditions, such as acne or eczema, please inform your practitioner prior to the treatment.

Drink plenty of water and eat a healthy diet in the days leading up to the treatment to promote healthy skin and optimal healing.

Arrive at your appointment with clean, makeup-free skin to allow for a thorough cleansing and preparation of the treatment area.

CHEMICAL PEEL
Consent & Liability

I, ___________________________, hereby consent to receive a chemical peel treatment at High Tide Beauty Bar, LLC. I understand that this procedure involves the application of a chemical solution to my skin, which may cause the outermost layers to peel, revealing new, smoother skin underneath.

I have been informed about the following aspects of the chemical peel treatment:

1. Purpose: The purpose of the chemical peel is to improve the appearance and texture of my skin, reduce signs of aging, treat acne or other skin conditions, as discussed with the practitioner.

2. Risks and Side Effects: I understand that chemical peels may involve risks, including but not limited to redness, swelling, peeling, scarring, infection, pigmentation changes, and allergic reactions.

3. Alternatives: I have been informed of alternative treatments or procedures and have chosen the chemical peel after considering these options.

4. Aftercare: I understand that proper post-treatment care is essential, including sun protection and avoidance of certain skincare products. I will follow the provided aftercare instructions.

5. Results: The outcome of the chemical peel can vary from person to person. I understand that I may need multiple sessions to achieve the desired results.

6. Costs: I am aware of the total cost of the procedure, any additional fees, and the clinic's refund and cancellation policy.

I have had the opportunity to ask questions and discuss any concerns I may have regarding the chemical peel treatment. I understand the procedure's potential risks and benefits and voluntarily consent to undergo the treatment.

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Client printed Name	*Client signature*	*Date*

CHEMICAL PEEL
Client Intake

GENERAL INFORMATION

Name: .... Date: ....

Date of birth: .... Age: .... ◯Female ◯Male ◯NB

Address: ....

City: .... State: .... Zip: ....

Phone: .... Email: ....

MEDICAL HISTORY

Please check any that condition that apply to you:

- ◯ Acne
- ◯ Lupus Heart disease
- ◯ Autoimmune disorders
- ◯ Hepatitis
- ◯ Migraines
- ◯ Phlebitis/blood clots
- ◯ Asthma
- ◯ Herpes simplex
- ◯ Cold sores, fever blisters
- ◯ High/low blood pressure
- ◯ Dermatitis
- ◯ Psoriasis
- ◯ Hives
- ◯ COPD
- ◯ Rosacea
- ◯ Cancer
- ◯ Skin infections
- ◯ Seborrhea
- ◯ Diabetes
- ◯ Hemophilia
- ◯ HIV/AIDS
- ◯ Thyroid condition
- ◯ Eczema
- ◯ Hyper/hypo pigmentation
- ◯ Tinea
- ◯ Epilepsy
- ◯ Hysterectomy
- ◯ Varicose veins
- ◯ Glaucoma
- ◯ Keloid, hypertrophic scars
- ◯ Warts

Any other conditions: ....

Any known allergies? ....

Any recent surgery, including plastic surgery? ....

List any medications you take regularly, including vitamins, herbal supplements, and aspirin:

....

CHEMICAL PEEL
Client Intake

Do you have a history of sunburn or excessive sun exposure? ◯ No ◯ Yes

Are you pregnant or nursing? ◯ No ◯ Yes

Have you ever had a reception to skincare products or treatments in the past? ◯ No ◯ Yes

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SKIN TYPE

◯ Sensitive skin
◯ Dry skin
◯ Rosacea-prone skin
◯ Oily skin
◯ Normal skin
◯ Sun-damaged skin
◯ Aging skin
◯ Psoriasis-prone skin
◯ Dehydrated skin
◯ Combination skin
◯ Hyperpigmented skin
◯ Acne-prone skin

I understand that Microdermabrasion is a cosmetic treatment and not a medical procedure. I have provided accurate information to the best of my knowledge. I have been informed about the potential risks and benefits of this treatment. I consent to the Microdermabrasion facial and agree to follow post-treatment care instructions.

Client printed Name	*Client signature*	*Date*

MICRODERMABRASION
Client Intake

GENERAL INFORMATION

Name: .... Date: ....

Date of birth: .... Age: .... ◯Female ◯Male ◯NB

Address: ....

City: .... State: .... Zip: ....

Phone: .... Email: ....

MEDICAL HISTORY

Please check any that condition that apply to you:

- ◯ Acne
- ◯ Lupus Heart disease
- ◯ Autoimmune disorders
- ◯ Hepatitis
- ◯ Migraines
- ◯ Phlebitis/blood clots
- ◯ Asthma
- ◯ Herpes simplex
- ◯ Cold sores, fever blisters
- ◯ High/low blood pressure
- ◯ Dermatitis
- ◯ Psoriasis
- ◯ Hives
- ◯ COPD
- ◯ Rosacea
- ◯ Cancer
- ◯ Skin infections
- ◯ Seborrhea
- ◯ Diabetes
- ◯ Hemophilia
- ◯ HIV/AIDS
- ◯ Thyroid condition
- ◯ Eczema
- ◯ Hyper/hypo pigmentation
- ◯ Tinea
- ◯ Epilepsy
- ◯ Hysterectomy
- ◯ Varicose veins
- ◯ Glaucoma
- ◯ Keloid, hypertrophic scars
- ◯ Warts

Any other conditions:

....

Any known allergies?

....

Any recent surgery, including plastic surgery?

....

List any medications you take regularly, including vitamins, herbal supplements, and aspirin:

....

MICRODERMABRASION Client Intake

Do you have a history of sunburn or excessive sun exposure? ◯ No ◯ Yes

Are you pregnant or nursing? ◯ No ◯ Yes

Have you ever had a reaction to skincare products or treatments in the past? ◯ No ◯ Yes

---

SKIN TYPE

◯ Sensitive skin
◯ Dry skin
◯ Rosacea-prone skin
◯ Oily skin
◯ Normal skin
◯ Sun-damaged skin
◯ Aging skin
◯ Psoriasis-prone skin
◯ Dehydrated skin
◯ Combination skin
◯ Hyperpigmented skin
◯ Acne-prone skin

I understand that Microdermabrasion is a cosmetic treatment and not a medical procedure. I have provided accurate information to the best of my knowledge. I have been informed about the potential risks and benefits of this treatment. I consent to the Microdermabrasion facial and agree to follow post-treatment care instructions.

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Client printed Name	*Client signature*	*Date*

MICRODERMABRASION
Consent & Liability

I,____________________________________, hereby consent to undergo a Microdermabrasion treatment at High Tide Beauty Bar, LLC.

Microdermabrasion is a non-invasive cosmetic procedure that involves the mechanical exfoliation of the top layer of skin using a specialized device. It is intended to improve skin texture, reduce the appearance of fine lines, and promote overall skin rejuvenation.

<u>I understand and agree to the following:</u>

1. I have been informed about the risks, benefits, and potential side effects of Microdermabrasion, including but not limited to redness, mild discomfort, and skin sensitivity.

2. I have disclosed all relevant medical conditions, allergies, medications, and skin concerns to my therapist.

3. I have been advised to avoid sun exposure and the use of certain skincare products before and after the procedure, as instructed by my therapist.

4. I will follow post-care instructions provided by my therapist to minimize any potential complications

I release High Tide Beauty Bar, LLC from any liability associated with the Microdermabrasion treatment, except in cases of negligence or willful misconduct.

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Client printed Name	*Client signature*	*Date*

DERMAPLANING
Client Intake

GENERAL INFORMATION

Name: .... Date: ....

Date of birth: .... Age: .... ◯Female ◯Male ◯NB

Address: ....

City: .... State: .... Zip: ....

Phone: .... Email: ....

MEDICAL HISTORY

Please check any of the following medical conditions that apply to you:

- ◯ High blood pressure
- ◯ Low blood pressure
- ◯ Heart disease
- ◯ Diabetes
- ◯ Thyroid condition
- ◯ Autoimmune disease
- ◯ Cancer
- ◯ Epilepsy
- ◯ Keloid scarring
- ◯ Blood clotting disorder
- ◯ Hepatitis
- ◯ HIV/AIDS
- ◯ Active infection
- ◯ Skin condition (please specify): ....
- ◯ Other medical conditions (please specify): ....

If you checked any of the above, please give details: ....

Any other conditions: ....

List any medications you take regularly, including vitamins, herbal supplements aspirin: ....

Have you had any facial surgeries or procedures in the last six months? ◯Yes ◯No If yes, please specify ....

Do you have any allergies? ◯Yes ◯No If yes, please specify ....

Are you currently pregnant or nursing? ◯Yes ◯No ....

Do you have any medical conditions or take any medications that may affect your skin or healing process? ◯Yes ◯No If yes, please specify ....

DERMAPLANING
Client Intake

Do you have a history of cold sores or fever blisters? ◯Yes ◯No

Have you ever had an adverse reaction to any skincare or facial treatment? ◯Yes ◯No

Have you had a chemical peel or microdermabrasion in the last two weeks? ◯Yes ◯No

Have you used Accutane or any other acne medication in the last six months? ◯Yes ◯No

Have you used Retin-A, Renova, or any other retinoids in the last two weeks? ◯Yes ◯No

Have you used any topical prescription creams in the last two weeks? ◯Yes ◯No

Have you used any topical prescription creams in the last two weeks? ◯Yes ◯No

Have you used any exfoliating products (such as scrubs or enzymes) in the last two weeks? ◯Yes ◯No

Have you used any self-tanning products in the last two weeks? ◯Yes ◯No

Have you used any facial waxing or threading in the last two weeks? ◯Yes ◯No

Are you currently using any products containing alpha-hydroxy acids, glycolic acids, or salicylic acids?

◯Yes ◯No

Do you have any active skin infections or conditions (such as eczema or psoriasis) on your face?

◯Yes ◯No

Do you have any broken skin or open wounds on your face? ◯Yes ◯No

I acknowledge that I am responsible for providing accurate and up-to-date information.

Client printed Name	*Client signature*	*Date*

DERMAPLANING
Consent Form

I, ________________________ , hereby consent to receive a Dermaplaning Facial treatment from High Tide Beauty Bar, LLC. I understand that the Dermaplaning Facial treatment involves the use of a small scalpel to exfoliate the surface of my skin, removing dead skin cells, peach fuzz, and other debris.

I understand that there are certain risks and side effects associated with the Dermaplaning Facial treatment, including but not limited to: Redness, Swelling, Irritation, Sensitivity, Discomfort or pain, Infection, Scarring, Changes in skin texture or pigmentation...

I understand that it is important to follow all post-treatment instructions provided by my esthetician in order to minimize the risk of these side effects.

I also understand that the Dermaplaning Facial treatment may not be suitable for individuals with certain skin conditions, including but not limited to active acne, rosacea, eczema, or psoriasis.

I have disclosed any such conditions to my esthetician prior to treatment.

I hereby release and hold harmless of High Tide Beauty Bar, LLC, its owners, employees, and agents from any and all claims, damages, or injuries that may arise from or in connection with the Dermaplaning Facial treatment.

I have read and understand the information provided above and hereby give my informed consent to receive the Dermaplaning Facial treatment.

--	--	--
Client printed Name	*Client signature*	*Date*

DERMAPLANING

Aftercare Advice

After undergoing a Dermaplaning Facial treatment, it is important to follow these aftercare instructions in order to minimize the risk of side effects and achieve the best possible results

Sun Protection: Avoid sun exposure for 24 hours or wear SPF 30+.

Makeup: Don't use makeup for 24 hours.

Skincare Products: Avoid harsh products for 48 hours. No retinol, AHA, or BHA for 72 hours.

Touching Your Face: Avoid touching or picking at skin for 48 hours.

Water and Steam: Avoid hot water, steam, and saunas for 48 hours.

Cleansing: Use a gentle cleanser and cool water to wash your face.

Moisturizing: Apply a soothing moisturizer.

Exercise: Avoid sweating or strenuous exercise for 24 hours.

FACIAL TREATMENT
Client Intake Form

CLIENT INFORMATION

Name: Date:

Date of birth: Age: ◯ Female ◯ Male ◯ NB

Address: City: State:

Email: Zip:

Phone: Emergency Contact:

MEDICAL HISTORY

Please select all that apply:

- ◯ Acne
- ◯ Lupus Heart disease
- ◯ Autoimmune disorders
- ◯ Hepatitis
- ◯ Migraines
- ◯ Phlebitis/blood clots
- ◯ Asthma
- ◯ Herpes simplex
- ◯ Cold sores, fever blisters
- ◯ High/low blood pressure
- ◯ Dermatitis
- ◯ Psoriasis
- ◯ Hives
- ◯ COPD
- ◯ Rosacea
- ◯ Cancer
- ◯ Skin infections
- ◯ Seborrhea
- ◯ Diabetes
- ◯ Hemophilia
- ◯ HIV/AIDS
- ◯ Thyroid condition
- ◯ Eczema
- ◯ Hyper/hypo pigmentation
- ◯ Tinea
- ◯ Epilepsy
- ◯ Hysterectomy
- ◯ Varicose veins
- ◯ Glaucoma
- ◯ Keloid, hypertrophic scars
- ◯ Warts

Any other conditions:

Any known allergies?

Any recent surgery, including plastic surgery?

List any medications you take regularly, including vitamins, herbal supplements, and aspirin:

FACIAL TREATMENT
Client Intake Form

SKIN TYPE

- ◯ Sensitive skin
- ◯ Dry skin
- ◯ Rosacea-prone skin
- ◯ Oily skin
- ◯ Normal skin
- ◯ Sun-damaged skin
- ◯ Aging skin
- ◯ Psoriasis-prone skin
- ◯ Dehydrated skin
- ◯ Combination skin
- ◯ Hyperpigmented skin
- ◯ Acne-prone skin

Specific problem areas on your face?

....

SKINCARE CONCERNS

- ◯ Acne
- ◯ Rosacea
- ◯ Scars
- ◯ Age spots
- ◯ Fine lines and wrinkles
- ◯ Blackheads
- ◯ Hyperpigmentation
- ◯ Skin redness
- ◯ Ingrown hairs
- ◯ Millia
- ◯ Broken capillaries
- ◯ Dark circles
- ◯ Sun damage
- ◯ Keratosis pilaris
- ◯ Thin skin
- ◯ Melasma
- ◯ Dehydrated skin
- ◯ Under-eye puffiness
- ◯ Dry skin
- ◯ Oily skin
- ◯ Uneven skin texture
- ◯ Eczema
- ◯ Uneven skin tone
- ◯ Premature aging
- ◯ Whiteheads
- ◯ Psoriasis
- ◯ Enlarged pores
- ◯ Facial hair
- ◯ Razor burn
- ◯ Dull skin

PLEASE CHECK THE CURRENT PRODUCTS YOU USE:

- ◯ Spot treatment
- ◯ Serum
- ◯ Retinol
- ◯ Toner
- ◯ Sunscreen
- ◯ Day cream
- ◯ Foam cleanser
- ◯ Night cream
- ◯ Exfoliants
- ◯ Gel cleanser
- ◯ Facial soap
- ◯ Facial oils
- ◯ Eye makeup remover
- ◯ Eye cream
- ◯ Mask

FACIAL TREATMENT
Client Intake Form

FEMALE CLIENTS

Are you pregnant or trying to become pregnant? ◯ No ◯ Yes

Do you use any hormonal birth control methods? ◯ No ◯ Yes

Are you undergoing any hormone replacement therapy? ◯ No ◯ Yes

LIFESTYLE QUESTIONS

What is your sun exposure?

◯ Never ◯ Light ◯ Moderate ◯ Excessive

What is your alcohol consumption?

◯ None ◯ Occasionally ◯ Few times a week ◯ Daily

Do you use sun protection (sunscreen, hats, protective clothing)? ◯ No ◯ Yes

Do you use tanning beds? ◯ No ◯ Yes

Do you smoke? ◯ No ◯ Yes

Do you drink more than 4 caffeinated beverages a day? ◯ No ◯ Yes

What is your occupation?

SKINCARE HISTORY

Have you had an allergic reaction to any of the following:

◯ Alpha hydroxyl acids
◯ Shellfish
◯ Medication
◯ Food
◯ Animals
◯ Sunscreen
◯ Nuts
◯ Fragrance
◯ Aspirin Cosmetics
◯ Pollen
◯ Lodine
◯ Essential oils
◯ Latex
◯ Skin products
◯ Other

FACIAL TREATMENT
Client Intake Form

If you checked any of the allergic reactions, please specify:

....

ARE YOU CURRENTLY USING PRODUCTS CONTAINING ANY OF THE FOLLOWING INGREDIENTS?

- ◯ Renova/Retinoids
- ◯ Exfoliating scrub
- ◯ Vitamin A derivative (i.e. retinol)
- ◯ Hydroxyl acids (AHAS)
- ◯ Beta hydroxyl acids (BHAS)
- ◯ Hydroquinone

If you checked any above, please explain:

....

Any History of previous facials, microdermabrasion, peels or other treatments?

....

Have you in the last 3 months used Retin-A, Renova, AHA's, or Retinol\vitamin A derivate products?

....

Have you had collagen, Restylane, or Botox injections within the last six months?If yes, please explain:

....

Have you ever used any acne medication? ◯ No ◯ Yes

How does your skin heal? ◯ Slow ◯ Fast ◯ Pigments ◯ Scars

Do you get bruises easily? ◯ Never ◯ Light ◯ Moderate ◯ Excessive

BY SIGNING BELOW, YOU AGREE TO THE FOLLOWING:

I have filled out this form as completely and truthfully as I can. I consent to update the technician on any changes to the previously provided information. I consent to release my technician and the employer from all liability for any harm or losses brought on by any falsification of my medical history.

--	--	--
Client printed Name	*Client signature*	*Date*

FACIAL TREATMENT
Skin Analysis Form

CLIENT INFORMATION

Name: .... Date: ....

Date of birth: .... Age: .... ◯ Female ◯ Male ◯ NB

Email: .... Phone: ....

Known allergies: ....

Medications: ....

SKIN TYPE:	◯ Normal ◯ Oily	◯ Sensitive ◯ Dry	◯ Dehydrated ◯ Combination	
ACNE:	◯ I	◯ II	◯ III	◯ IV
ELASTICITY:	◯ Excellent	◯ Good	◯ Fair	◯ Poor
MOISTURE CONTENT:	◯ Excellent	◯ Good	◯ Fair	◯ Poor
PORES:	◯ Fine	◯ Dilated	◯ Comedones	◯ Poor
SKIN SENSITIVITY:	◯ Not sensitive ◯ Hyper Sensitive	◯ Mildly sensitive		◯ Sensitive
FINE LINES:	◯ I - None ◯ III - Wrinkles at rest		◯ II - Wrinkles in motion ◯ IV -Mostly wrinkles	
FITZPATRICK SCALE	◯ I	◯ II	◯ III	◯ IV

FACIAL TREATMENT
Skin Analysis Form

CLIENT INFORMATION

Name: Date:

Date of birth: Age: ◯ Female ◯ Male ◯ NB

Email: Phone:

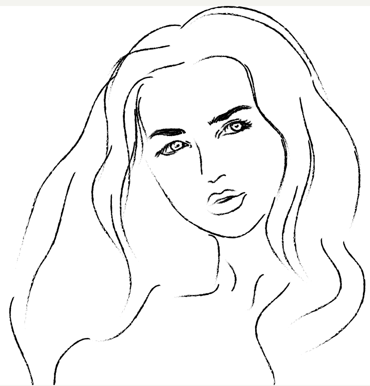
SKIN TYPE: ◯ Normal ◯ Oily ◯ Sensitive ◯ Dry ◯ Combination

FINE LINES:

◯ I - None ◯ II - Wrinkles in motion ◯ III - Wrinkles at rest ◯ IV -Mostly wrinkles

FITZPATRICK SCALE ◯ I ◯ II ◯ III ◯ IV

SKIN SENSITIVITY:	ELASTICITY:	MOISTURE CONTENT:	PORES:	ACNE:
◯ Not sensitive	◯ Excellent	◯ Excellent	◯ Fine	◯ I
◯ Mildly sensitive	◯ Good	◯ Good	◯ Dilated	◯ II
◯ Sensitive	◯ Fair	◯ Fair	◯ Comedones	◯ III
◯ Hyper Sensitive	◯ Poor	◯ Poor	◯ Milia	◯ IV



Comedones	C	Keloids	K
Papules	PA	Hyperpigmentation	H+
Milia	MI	Hypopigmentation	H-
Spider Veins	SV	Moles	MO
Rosacea	R	Psoriasis	PS
Cherry Angioma	CA	Telangiectasia	T
Skin Tags	ST	Eczema	E
Warts	W	Sunburn	SB
Scars	SC	Pustules	PU
Asphyxiated	AX		

Notes

High Tide
BEAUTY BAR

FACIAL TREATMENT

Client treatment record

CLIENT INFORMATION

Name: Date:

Date of birth: Age: ◯Female ◯Male ◯NB

Email: Phone:

DATE	TREATMENT	PRODUCTS	NOTES	PRICE

FACIAL TREATMENT

Client consent form

I, ____, hereby consent to receive a facial treatment at High Tide Beauty Bar, LLC on the date: ______________________________
I understand that the facial treatment may include but is not limited to cleansing, exfoliation, extraction, mask application, massage, and the use of various skincare products and equipment as recommended by the esthetician.

I have disclosed all medical conditions, allergies, medications, and skincare products I am currently using on the Client Health History form provided by High Tide Beauty Bar, LLC, and I understand that this information will be used to determine the suitability of the treatment and products used during my facial.

I understand that there are potential risks associated with facial treatments, including but not limited to: Skin irritation or redness, Allergic reactions, Post-treatment breakouts, Infection (if proper aftercare is not followed), skin sensitivity, scarring (in rare cases).

I have had the opportunity to ask questions about the treatment, and all my questions have been answered to my satisfaction. I understand that the esthetician will use their professional judgment to determine the treatment techniques and products used during the facial.

I understand that results may vary, and I may require multiple sessions to achieve the desired outcome.

I acknowledge that I have been informed of the importance of following post-treatment instructions provided by the esthetician to minimize any potential risks or side effects.

I release High Tide Beauty Bar, LLC and its staff from any liability associated with the facial treatment, except for cases of negligence or willful misconduct.

I certify that I am over the age of 18 and have read and understood the information provided in this consent form. I have been given the opportunity to ask questions and have received satisfactory answers.

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Client printed Name	*Client signature*	*Date*

FACIAL TREATMENT

Aftercare Advice

Congratulations on completing your facial treatment! Proper aftercare is essential to maximize the benefits of the treatment and maintain healthy, glowing skin. Here are some guidelines for your post-facial care:

- Avoid touching your face for at least 24 hours after the treatment to prevent transferring bacteria to your skin.
- Avoid direct sunlight and use sunscreen with at least SPF 30 to protect your skin from any further damage.
- Avoid using any harsh creams, toners, or exfoliants on your skin for the next 24-48 hours, as they may cause irritation.
- Drink plenty of water and stay hydrated to help your skin recover faster.
- Avoid smoking and alcohol consumption, as they can dehydrate your skin and slow down the healing process.
- Be gentle with your skin while washing your face and avoid using hot water. Use lukewarm water and a gentle cleanser to cleanse your face.
- Avoid using makeup for the next 24 hours after the treatment to allow your skin time to breathe.
- If you experience any discomfort or excessive redness, apply a cold compress to your face to reduce swelling.
- Remember to take good care of your skin to maintain the results of your facial treatment.