Confidential Client Intake Form

BELLE Naturelle

General Information

Name | Date of Birth

Address

City | State | Zip Code

Phone # | Email

Occupation

Emergency Contact Name | Phone #

Would you like to be added to our email list for specials and discounts? Yes ☐ No ☐

How did you hear about us?

Medical History

Please check all that apply:

- ☐ Acne
- ☐ Diabetes
- ☐ Fever Blisters
- ☐ High Blood Pressure
- ☐ Hypo Pigmentation
- ☐ Lupus
- ☐ Pregnant
- ☐ Seborrhea
- ☐ Hype/Hypo Thyroid
- ☐ Arthritis
- ☐ Eczema
- ☐ Heart Condition
- ☐ HIV
- ☐ Insomia
- ☐ Sinus Infection
- ☐ Psoriasis
- ☐ Shingles
- ☐ Warts
- ☐ Depression
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Hyper Pigmentation
- ☐ Low Blood Pressure
- ☐ Surgery:
- ☐ Rashes
- ☐ Skin Cancer
- ☐ Other: _____

Are you currently taking any medications? Yes ☐ No ☐

If yes, please explain:

Have you had any facial or dermatology services in the past 30 days? Yes ☐ No ☐

If yes, please explain:

Do you have any allergies? Yes ☐ No ☐

If yes, please explain:

Skin Care History

Check the products that you currently use (please select all that apply):

- ☐ Body Lotion
- ☐ Cleansing Cream
- ☐ Eye Cream
- ☐ Facial Scrub
- ☐ Night Cream
- ☐ Body Soap
- ☐ Day Cream
- ☐ Exfoliants
- ☐ Hand Cream
- ☐ Skin Toner/Astringent
- ☐ Body Scrub
- ☐ Eye Makeup Remover
- ☐ Facial Soap
- ☐ Neck Cream
- ☐ Other: _____

What type of skin do you have?

☐ Normal ☐ Oily ☐ Dry ☐ Combination ☐ Unsure

Conditions you are currently experiencing today (please select all that apply):

☐ Anxiety ☐ Fatigue ☐ Forgetfulness ☐ Headache
☐ Inflammation ☐ Insomia ☐ Muscle Cramps ☐ Stress

Important Information

What concerns do you have regarding your skin? Please select all that apply:

☐ Acne/Breakouts
☐ Blackheads/Whiteheads
☐ Broken Capillaries
☐ Clogged Pores
☐ Dark Spots
☐ Dryness
☐ Excessive Oil/Shine
☐ Redness
☐ Rosacea
☐ Scarring
☐ Sun Damage
☐ Uneven Skin Tone
☐ Unwanted Hair
☐ Wrinkles/Fine Lines
☐ Other: _____

Have you been under the care of a dermatologist within the past year? Yes ☐ No ☐

If yes, please explain:

Have you used Retin-A, Renova, AHAs or Retinal/Vitamin A products in the last three months? Yes ☐ No ☐

If yes, please explain:

Have you received Botox, Restylane, or Collagen injections in the last 6 months? Yes ☐ No ☐

By signing below, I agree to the following:

I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

_____ _____ _____

Name Printed Signature Date

Client Consent Form & Liability Waiver

I hereby consent to and authorize _____ to perform the following procedure:

_____

I have voluntarily elected to undergo this treatment/procedure after the nature and purpose of this treatment have been explained to me.

I understand and acknowledge that there are risks involved with the treatment I will be receiving. Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications, and I have had the opportunity to ask questions regarding these risks and other possible complications.

I also recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle, and that there is a possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.

I have read and understood the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician immediately.

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. I agree I will assume the risk and full responsibility for any and all injuries, losses, side effects, or damages that might occur to me while I am undergoing this procedure. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skincare procedure, which may be affected by the treatment performed today.

Printed Name	Signature	Date
Esthetician Name	Signature	Date

Photograph and Video Release Form

I, _____ hereby grant and authorize _____ the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures, video, and/or audio is taken of me to be used in and/or for any lawful promotional materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, press kits, websites, social networking sites, and other print or digital communications without payment or any other consideration. This authorization extends to all languages, media, formats, and markets now known or later discovered. I waive the right to inspect or approve the finished product wherein my likeness appears, including a written or electronic copy. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. I hereby hold harmless and release _____ from all liability, petitions, and causes of action which I, my heirs, representatives, executors, or any other persons may make while acting on my behalf or on behalf of my estate.

Picture/Video/Audio Description:

Date taken:

_____ Name Printed

_____ Signature

_____ Date

Covid-19 Liability Release Form

Due to COVID-19, we are taking extra precautions with each client and have improved our sanitation and disinfecting practices. Please complete the following and sign below.

☐ I confirm that I, nor anyone in my household have any of the following symptoms of COVID-19 listed below, nor have had any of the following symptoms in the past 14 days:

- ☐ Fever
- ☐ Chills
- ☐ Cough
- ☐ Shortness of breath
- ☐ Difficulty breathing
- ☐ Fatigue
- ☐ Muscle aches
- ☐ Body aches
- ☐ Headache
- ☐ New loss of taste or smell
- ☐ Sore throat
- ☐ Congestion or runny nose
- ☐ Nausea or vomiting
- ☐ Diarrhea

☐ To the best of my knowledge, neither I nor anyone in my household has been in contact with anyone who has tested positive for COVID-19. _____ (initial)

☐ I verify that neither I nor anyone in my household has traveled outside of _____ in the past 14 days. _____ (initial)

☐ I understand that the CDC recommends social distancing of at least 6 feet, and this is not possible with the service I am receiving today. _____ (initial)

By signing below I knowingly and willingly consent to release any and all liability for the unintentional exposure or harm due to COVID-19.

Name Printed	Signature	Date
_____	_____	_____

Confidential Client Intake Form for Sugar Waxing

BELLE Laturelle

General Information

Name | Date of Birth

Address

City | State | Zip Code

Phone # | Email

Occupation

Emergency Contact Name | Phone #

Would you like to be added to our email list for specials and discounts? Yes ☐ No ☐

How did you hear about us?

Service(s) Being Performed

Face & Brows

- ☐ Brows
- ☐ Lip
- ☐ Chin
- ☐ Full Face
- ☐ Side Burns

Upper Body

- ☐ Full Arms
- ☐ Half Arms
- ☐ Underarms
- ☐ Back/Shoulder
- ☐ Abdomen
- ☐ Chest

Lower Body

- ☐ Full Legs
- ☐ Half Legs

Other

- ☐ Brazilian
- ☐ Bikini
- ☐ Full Body
- ☐ Other: _____

Medical History

Please check all that apply:

- ☐ Acne
- ☐ Diabetes
- ☐ Fever Blisters
- ☐ High Blood Pressure
- ☐ Hypo Pigmentation
- ☐ Lupus
- ☐ Pregnant
- ☐ Seborrhea
- ☐ Hype/Hypo Thyroid
- ☐ Arthritis
- ☐ Eczema
- ☐ Heart Condition
- ☐ HIV
- ☐ Insomia
- ☐ Sinus Infection
- ☐ Psoriasis
- ☐ Shingles
- ☐ Warts
- ☐ Depression
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Hyper Pigmentation
- ☐ Low Blood Pressure
- ☐ Surgery:
- ☐ Rashes
- ☐ Skin Cancer
- ☐ Other: _____

Have you ever been treated for cancer? Yes ☐ No ☐

If yes, when and what types of therapies were used?

Are you currently taking any medications? Yes ☐ No ☐

If yes, please list:

Do you have any allergies? Yes ☐ No ☐

If yes, please explain:

Skin Care History

Please list any skin care products that you currently use:

Have you used any AHA products in the last 72 hours?	☐ Yes	☐ No
Are you using Retin-A, Renova, or Accutane?	☐ Yes	☐ No
Are you using any other skin thinning products and/or drugs?	☐ Yes	☐ No
Are you exposed to the sun on a daily basis?	☐ Yes	☐ No
Do you currently have a sunburn?	☐ Yes	☐ No
Do you plan on spending more time in the sun soon?	☐ Yes	☐ No
Have you recently used a tanning bed?	☐ Yes	☐ No
Have you recently had a chemical or glycolic peel?	☐ Yes	☐ No
Have you waxed before?	☐ Yes	☐ No

If yes, when?

If yes, did you have any adverse reactions? Yes ☐ No ☐

If yes, please explain:

Do you have any abrasions, moles, or skin irritations in the areas being waxed today? Yes ☐ No ☐

If yes, please explain:

(Female clients) When is your next menstrual cycle due to begin?_____

(For your own comfort, we recommend avoiding hair removal from two days before to two days after your cycle.)

By signing below, I agree to the following:

I have completed this form to the best of my ability and knowledge. I agree to inform the technician of any changes in the above information. I agree that I do not have any condition(s) that would make the requested treatment unsuitable. I will inform the technician of any discomfort I may experience at any time during my treatment to allow them to adjust accordingly. I agree to waive all liability toward my technician and the salon for any injury or damages incurred due to any misrepresentation of my health.

Name Printed	Signature	Date
Esthetician Name Printed	Signature	Date

Client Consent Form & Liability Waiver

I hereby consent to and authorize _____ to perform the following waxing procedure:

_____

I understand that waxing may have certain side effects which may include but are not limited to skin removal, redness, swelling, and tenderness. I have had the opportunity to ask questions regarding these side effects and other possible complications. I give permission to my esthetician to perform the waxing procedure we have discussed and I will hold them and the spa harmless from any liability that may result from this treatment.

I have read and understand the aftercare home care instructions. I understand how important it is to follow all instructions given to me for aftercare. In the event that I may have additional questions or concerns regarding my treatment and suggested aftercare, I will consult the esthetician immediately.

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. I agree I will assume the risk and full responsibility for any and all injuries, losses, side effects, or damages that might occur to me while I am undergoing this procedure. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skincare procedure, which may be affected by the treatment performed today.

Name Printed	Signature	Date
Esthetician Name	Signature	Date

Informed Consent for Microdermabrasion

I, _____ give my consent for microdermabrasion to be performed by

_____

Please read and initial each of the statements below:

_____ I certify I am over the age of 18.
_____ I have voluntarily elected to receive microdermabrasion after the nature and purpose of this treatment has been explained to me.
_____ I understand that microdermabrasion can be used to diminish the appearance of fine lines and wrinkles, improve texture/tone, reduce pore size, increase hydration and moisture retention, give skin a smoother appearance and diminish the appearance of hyperpigmentation.
_____ I understand that the following conditions preclude me from having this treatment at this time and verify that none of the following conditions apply to me at this time:

- Pregnancy/Lactating
- Herpes Simplex (cold sores or fever blisters)
- Unhealthy or broken skin
- Inflammation
- Extensive sun or tanning 3 days prior and 3 days post-treatment
- Accutane in the past 6 months to 1 year
- Glycolic acid products, Retin-A or Renova in the last 4 weeks
- Waxing the area to be treated in the past 7 days
- Any other chemical peel within 8 weeks of the treatment

_____ I recognize there are no guaranteed results and that independent results are dependent upon age, skin condition, and lifestyle, and that there is a possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost.
_____ I understand and acknowledge that there are risks involved with the treatment I will be receiving including, but not limited to:

- Mild to moderate discomfort or pain
- Acne or milia breakout
- Slight redness or swelling
- Itching or irritation
- Sun sensitivity
- Skin sensitivity
- Pigment changes
- Scarring
- Allergic reaction
- Bacterial infection
- Skin peeling or flaking up to 14 days after the procedure

_____ I have been informed of possible benefits, risks, and complications, and I have had the opportunity to ask questions regarding these risks and other possible complications.

_____ I have read and understood the post-treatment home care instructions. I understand how important it is to follow all instructions given to me for post-treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult the esthetician immediately.

_____ I understand that direct sun exposure is prohibited while I am undergoing treatment and that the use of sunblock protection with a minimum of SPF 15 is mandatory.

_____ I agree to refrain from excessive sun exposure or the use of a tanning bed while I am undergoing treatment and during the 14 days following the end of the treatment.

_____ I have, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

I have read and fully understand this agreement and all information detailed above. I understand the procedure and accept the risks. I agree I will assume the risk and full responsibility for any and all injuries, losses, side effects, or damages which might occur to me while I am undergoing this procedure. I do not hold the esthetician, whose signature appears below, responsible for any of my conditions that were present, but not disclosed at the time of this skin care procedure, which may be affected by the treatment performed today.

_____	_____	_____
Name Printed	Signature	Date
_____	_____	_____
Esthetician Name	Signature	Date

Consent Form for Dermaplaning

BELLE Naturelle

I, _____ give my consent for dermaplaning to be performed by

_____

Please read and initial each of the statements below:

_____ I certify I am over the age of 18.

_____ I understand that dermaplaning is a physical/mechanical form of exfoliation using a specialized dermaplaning blade for the removal of built-up dead skin cells and vellus hair. Following treatment skin will be smoother, softer, and better able to absorb the active ingredients in treatment and home care products.

_____ I have been informed of the nature, risks, and possible complications, and consequences of dermaplaning. I understand this treatment involves the use of the sterile, surgical blade to remove dead skin cells and vellus hair. As with the use of any sharp instrument, there is the possibility of nicks or cuts.

_____ I understand there are contraindications to this treatment, including but not limited to, diabetes (not controlled by diet or medication), cancer, active acne, bleeding disorders, the inability for blood to coagulate, or the development of keloids following injury. Certain medications including blood thinners, higher dosages of Aspirin, and Accutane are contraindicated for this treatment due to the possibility of delayed clotting from a nick or cut.

_____ I certify that I am not taking any of the above medications or experiencing any of the above conditions. While every precaution will be taken to avoid nicks, cuts, and scratches, I understand the risks and consent to treatment today.

_____ I understand that my technician only utilizes sterilized, disposable equipment to minimize the risk of infection or contamination and that my technician has received training inappropriate sanitation and hygiene techniques prior to performing any procedures. While the risk of infection from our procedures is extremely small, the possibility of such an occurrence cannot be totally prevented. Accordingly, I understand and accept the risk and release my technician and the spa from any and all liability related to the subject procedure, except instances involving gross negligence.

_____ I grant permission to _____ to take and use: photographs and/or digital images of me for use in news releases, educational materials and/or social media platforms including but not limited to Instagram, Facebook, Twitter, Tic Toc, and Pinterest.

By signing below, I agree to the following:
I have read or have had read to me the contents of this whole form. I understand the risks and alternatives involved in this/these procedure(s) and I have had the opportunity to ask questions and all of my questions have been answered. I accept full responsibility for the decision to have dermaplaning done and understand that there is a no refund policy. I acknowledge that I have reviewed and approved the material given to me.

Name Printed	Signature	Date
Esthetician Name	Signature	Date

Cancellation Policy

Your appointment is very important. We understand that sometimes schedule adjustments are necessary. Therefore, we respectfully request at least 24 hours' notice prior to your scheduled appointment time for cancellations or rescheduling of appointments. Please notify us by e-mail if your cancellation is outside of our normal business hours or you're unable to reach us by phone at _____

ANY APPOINTMENTS CANCELLED/RESCHEDULED OR CHANGED WITHOUT 24 HOURS NOTICE WILL RESULT IN A CHARGE EQUAL TO 50% OF THE RESERVED SERVICE AMOUNT. ALL "NO SHOWS" WILL BE CHARGED 100% OF THE RESERVED SERVICE AMOUNT.

We recognize the time of our clients and therapist is valuable and have implemented this policy for this reason. When you miss an appointment with us, we not only lose your business but also the potential business of other clients who could have scheduled an appointment for the same time.

Please remember that it is your responsibility to remember your appointment dates and times in order to prevent any missed appointments which result in a cancellation fee. Not receiving an electronic notification of your appointments from us is not sufficient reason to miss an appointment if the original confirmation notification was received timely.

It is mutually understood that if a cancellation is due to circumstances beyond any of our control, such as power outage, unfortunate incidence, illness, or weather that requires you or us to have to cancel or be closed during regular business hours, we will reschedule your existing appointment and no discount or rescheduling fee will apply.

I have read and understood the cancellation policy and agree to abide by the above conditions.

Name Printed	Signature	Date