



## WAXING CONSENT

### Personal Information

Name \_\_\_\_\_ Today's Date \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Contact's Phone \_\_\_\_\_  
Date of Birth \_\_\_\_\_

### Previous/Experience History

Are you currently taking Accutane? YES NO

Are you currently using Retin-A/Tretinoin/Renova/ Acne medicine? YES NO

Have you ever been waxed before today? YES NO

If yes, any complications? \_\_\_\_\_

Do you have any known allergies? If yes, please list: \_\_\_\_\_

**\*Please Note:** Waxing can be uncomfortable. Your therapist will use professional technique to attempt to minimize discomfort.

### Possible Complications with Waxing Procedures

Sensitive skin can burn from waxing procedures. Accutane and Retin-A or Tetinoin are drying to the skin, therefore waxing may lead to lifting (removal) of the skin, which may cause scarring. Waxing over sunburned or very tanned skin may lead to lifting, which may cause scarring. Diabetics have a very hard time healing when a wound or lesion occurs to the skin, as the immune system is unable to function fully to fighting bacteria. Allergies of the product ingredients used in waxing may cause an allergic reaction.

### Consent

I confirm to the best of my knowledge that the information I have provided is accurate and complete. I have not withheld any information that may be relevant to my treatment and/or the results thereof. I recognize it is my responsibility to inform my therapist of any changes in my physical conditon. I am aware that there are often inherent risks associated with waxing procedures, and the services I am abut to recieve could have unfavorable results including but not limited to: Allergic reactions, irritation, burning, redness, scarring, soreness etc. By signing below, I further agree that I will not hold Wellville Massage & Healing Arts or its contractors responsible should there be any unfavorable outcome or result.

I understand Wellville requires a 24 hour notice for all reschedules and cancellations with the only exception being medical emergencies for me or a member of my immediate family. Missed appointments will be charged at 50% of the scheduled service. I accept payment for missed appointments if I fail to provide the required notice.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_