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**Microcurrent Consent Form**

**This form must be filled in and signed by the customer wishing to begin a course of treatment. All treatments will be performed by fully trained operators using the recommended skincare products.**

Today’s Date: Name: Age: DOB:

Address: City: State: Zip:

Cell Phone: Home Phone: Work Phone:

Email Address (for birthday discount & other promotions): ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**All of the following questions are answered truthfully by me and I understand that some of the conditions may be contradictions to receiving microcurrent. Your skincare therapist will not accept any liability for injury or damages as a result of false information given below.**

1. Do you have any serious illness? **Yes**

**Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**

1. Have you any recent operations with general anesthetic? **Yes**

**Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**

1. Do you have a pacemaker? **Yes**

**Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**

1. Are you under any physical or psychological treatment? **Yes**

**Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**

1. Have you ever had Botox injections or Microdermabrasion? **Yes**

**Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**

1. Do you suffer from varicose veins? **Yes**

**Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**

1. Have you ever had laser treatments or Thermage? **Yes**

**Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**

1. Are you pregnant or trying to get pregnant? **Yes**

**Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**

1. Are you epileptic or suffer from fits? **Yes**

**Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**

1. Do you have any metal implants? **Yes**

**Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**

1. Have you suffered from any skin

conditions?  **Yes**

**Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**

1. Do you suffer from water retention?  **Yes**

**Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**

1. Do you have any hormonal imbalance that you know of? **Yes**

**Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**

1. Do you suffer from thyroid condition? **Yes**

**Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**

1. Do you smoke? **Yes**

**How many per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**

1. Are you or have you had chemotherapy or radiology treatment? **Yes** **Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**
2. Do you have low blood pressure or have cold hands and cold feet? **Yes** **Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**
3. What do you drink? Coffee/Tea/Alcohol per week?

\_\_\_\_\_ -cups of coffee/tea per day **Yes**

\_\_\_\_\_ - units of alcohol per day **No**

1. How many glasses of WATER do you drink per day?

**Cups per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Are you taking any medication? **Yes**

**Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**

1. Do you follow a skin care routine? **Yes**

**Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**

1. Do you have any known allergies? **Yes**

**Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**

1. Do you have sensitive skin? **Yes**

**Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**

1. Have you ever had an adverse reaction to electrical treatment before? **Yes**

**Details: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No**

DISCLAIMER OF LIABILITY WHERE PROHIBITED BY LAW. I AGREE THAT HAUTÍGO SPA, KPLOGIC LLC. AND EACH OF THEIR RESPECTIVE EMPLOYEES, OFFICERS, DIRECTORS, SHAREHOLDERS, MEMBERS, PARTNERS, AND AGENTS WILL NOT BE LIABLE FOR ANY ACCIDENT OR INJURY INCLUDING WITHOUT LIMITATION, PERSONAL, BODILY, OR MENTAL INJURY, ECONOMIC LOSS OR ANY DAMAGES TO ME, WHETHER RESULTING FROM NEGLIGENCE OR OTHERWISE RESULTING FROM MY PARTICIPATION IN ANY SERVICES OR PRODUCTS.

**Disclosures**

Photos may be taken before, during and after the Microcurrent treatment. Photos will only be used with my written approval for education, promotion or advertising purposes.

I authorize Hautigo Spa to use before and after pictures for education, promotion or advertising purposes. **Yes or No Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**RELEASE -** In exchange for this service and other good and valuable consideration. I and each of my heirs, executors, administrators, agents, and assigns, hereby release Skincare/Massage Therapist, HAUTÍGO SPA, KPLOGIC LLC, and each of their respective employees, officers, directors, shareholders, members, partners and agents, in their corporate and individual capacities, from any and all claims, demands, losses or causes of action that may have accrued as a result of my participation in any product or service provided to me and/or as a result of my use of the HAUTIGO facility.

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Guest Name (Please Print) Guest Signature Date

For guests under the age of 18, a parent or gaurdian will be responsible for reading, acknowledging and signing this Consent and Release for their child. No services will be performed on anyone under the age on 10 unless discussed with management.

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Parent or Gaurdian Name (Please Print) Parent or Gaurdian Signature Date