Welcome to Bella!

We are glad to have you as our guest. We encourage you to visit our website to see all of the exciting new laser and skincare treatments that we offer. Please be aware of our 24 hour cancellation policy. We look forward to pampering you and providing dramatic, lasting results.

A few tips to prepare you for your first visit:

Attached is your new patient paper work to fill out and bring with you to your first appointment.
We look forward to pampering you with dramatic, lasting results! Please feel free to call with any questions.

For all Laser Procedures:

-Can not be tanning, pregnant, or on Antibiotics
-Please shave the area to be treated right before your visit

For all Facial Procedures:

-Avoid Retin A & Glycolic 3 days before and after your procedure

Give the Gift of Bella

Gift Certificates are just $100 for a $150 value!

Enjoy this introduction video
to learn a little bit about Bella:

CLICK HERE

You can now schedule
appointments online!

CLICK HERE

OR

CLICK HERE

Client Information & Medical History

In order to provide you with the most appropriate laser treatment, we need you to complete the following questionnaire. *All information is strictly confidential.*

PERSONAL HISTORY

Client Name:

Today's Date:

Date of Birth:

Occupation:

Home Address:

City: State: Zip:

Home Phone: Work Phone:

Email:

Emergency Contact Name: Phone:

How were you referred to us?

Which of the following describes your skin type? (please select one)

- ☐ I Always burns, never tans
- ☐ II Always burns, sometimes tans
- ☐ III Sometimes burns, always tans
- ☐ IV Rarely burns, always tans
- ☐ V Brown, moderately pigmented skin
- ☐ VI Black skin

MEDICAL HISTORY

Are you currently under the care of a physician? ☐ Y ☐ N

If yes, for what?

Are you currently under the care of a dermatologist? ☐ Y ☐ N

If yes, for what?

MEDICAL HISTORY (cont.)

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? ☐ Y ☐ N

Do you have any of the following medical conditions? (please check all that apply)

☐ Cancer ☐ Diabetes ☐ High blood pressure ☐ Herpes ☐ Arthritis ☐ Frequent cold sores

☐ HIV/AIDS ☐ Keloid scarring ☐ Skin disease/skin lesions ☐ Seizure disorder ☐ Hepatitis

☐ Hormone imbalance ☐ Thyroid imbalance ☐ Blood clotting abnormalities ☐ Any active infection

Do you have any other health problems or medical conditions? Please list.

Have you ever had an allergic reaction to any of the following? (please check all that apply and describe the reaction you experienced.

☐ Food ☐ Latex ☐ Aspirin ☐ Lidocaine ☐ Hydrocortisone ☐ Hydroquinone or skin bleaching agents

☐ Others

What oral medications are you presently taking? ☐ Birth control pills ☐ Horomones ☐ Others (please list)

Are you on any mood altering or anti-depression medication? ☐ Y ☐ N

Have you ever used Accutane? ☐ Y ☐ N If yes, when did you last use it?

What topical medications or creams are you currently using? ☐ RetinA ☐ Others (please list)

What herbal supplements do you use regularly?

SKIN CARE HISTORY

Have you ever had laser hair removal? ☐ Y ☐ N

Have you used any of the following hair removal methods in the past six weeks?

☐ Shaving ☐ Waxing ☐ Electrolysis ☐ Plucking ☐ Tweezing ☐ Stringing ☐ Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? ☐ Y ☐ N

Have you recently used any self-tanning lotions or treatments? ☐ Y ☐ N

Do you form thick or raised scars from cuts or burns? ☐ Y ☐ N

SKIN CARE HISTORY (cont.)

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma.? ☐ Y ☐ N

If yes, please describe:

For our female clients:

Are you pregnant or trying to become pregnant? ☐ Y ☐ N

Are you breastfeeding? ☐ Y ☐ N

Are you using contraception? ☐ Y ☐ N

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures..

Signature Date:

Bella by Alethea / 4603 Wieuca Rd., Atlanta, GA 30342 / www.bellabyalethea.com

LATE CANCELLATION / NO SHOW CARD PAYMENT CONSENT FORM

Due to our extremely busy appointment schedule we are now requiring a form of payment to be kept on file to reserve an appointment time. In the case of a late cancellation without 24 hours notice or a no show to an appointment your card will be charged $50. Thank you for understanding.

Patient Name:

Name on Card:

Credit / Debit Card #:

Expiration:

Billing Zip Code:

I authorize Bella By Alethea Inc to charge my card for payment in the amount of $50 for a late cancellation without 24 hours notice or in the event of a no show to an appointment. I authorize these charges to my card. If I have questions I will contact Bella By Alethea and agree to not pursue a refund or dispute a $50 late cancellation or no show fee. I agree to pay any and all penalty fee(s) incurred by my provider, Bella By Alethea Inc.

Card holder signature

ACKNOWLEDGMENT, WAIVER, AND CONSENT TO RECEIVE SURGICAL AND DIAGNOSTIC PROCEDURES. DO NOT SIGN THIS FORM WITHOUT READING AND UNDERSTANDING ITS CONTENTS.

Name _____ DOB _____

Address _____

Phone (home) _____ Work _____

I acknowledge and understand that the following procedure(s) have been described to me and I hereby authorize Alethea, Inc. d/b/a Bella By Alethea, BA, its officers, directors, agents, contractors, and employees to perform such procedures:

I recognize that there are inherent risks in each of these procedures, and that the material risks associated with these procedures include, but are not limited to:
(a) For the following Laser Treatments: Intense Pulse Light (IPL, Laser Hair Removal, Laser Spot Removal, Refresh Laser Treatment, Wrinkle Reduction, Skin Tightening Laser Treatment, Leg/Facial vein removal, Radio Frequency Treatment, Scar Treatment, and the 755/1064 Laser Treatment (hereafter referred to as Laser Treatments possible major risks include infection, allergic reaction, severe loss of blood, loss of function of limbs or organs, paralysis, partial paralysis, paraplegia, quadrapalegia, disfiguring scars, brain damage, cardiac arrest, or death. _____ Initials

(b) Possible complications of the above-described Laser Treatments also include burning, blistering, scabbing, scars, hyperpigmentation and hypopigmentation, and possible lack of benefit. I have also been informed that if I am using Laser Treatments to treat lesions, depending on the size and color of the lesion being treated, complete clearing may not be possible or may take multiple treatments for the best results. I understand that immediately following any of the Laser Treatments identified herein that the area may appear as a red, brown or bruised discoloration and possibly slightly swollen. I understand any discoloration may last 7-14 days and there may be residual swelling lasting from a few minutes to several hours. I have read and understood all of the risks and possible side effects as outlined herein and agree that I want to pursue the Laser Treatments despite these risks. _____ Initials

Despite these risks, I hereby authorize BBA to perform the above-described procedures. I understand that some of the Laser Treatments may require multiple treatments to achieve the maximum benefit (approximately 3-5 during the next year). Laser Treatments utilize a device that produces an intense burst of light that reduces skin wrinkles and brown/red discoloration of the face/neck, and body without harming the surrounding tissue. To protect my eyes from the intense light I will have my eyes covered with opaque material or wear laser protective glass. I understand that I may not request that any cosmetic laser services be performed within one inch of the nearest part of the eye of the socket of my eye, because Georgia law prohibits BBA from performing any such cosmetic laser services. I hereby consent to the taking of photographs during the course of my laser therapy for the purpose of medical follow-up. _____ Initials

CONSENT REGARDING BEAUTY PRODUCTS:

"Beauty Procedures" include: Facials, Microdermabrasion, Eyelash Extensions, Massages, and Permanent Cosmetics. The material risks associated with these Beauty Procedures include: (1) For a "Facial and "Microdermabrasion the material risks associated with these procedures include blistering, scabbing, scarring, hyper/hypo pigmentation, allergic reaction to the treatment, and sun sensitivity; (2) For "Eyelash Extensions the material risks include itching, swelling, redness, allergic reaction, and eye sensitivity; (3) For "Massage the material risks are headaches, dizziness, bruising, sore muscles, and stiffness; (4) For "Permanent Cosmetics" the material risks are allergic reactions to the cosmetics, sensitivity, bleeding, loss of color, swelling, bruising, and sun sensitivity; "Waxing", the material risks associated with these procedures include blistering, scabbing, scarring, hyper/hypo pigmentation, allergic reaction to the treatment, and sun sensitivity. _____ Initials

Immediately before and 3 days following any skincare/beauty/laser procedure I will avoid the use of; sunbathing, tanning beds, sauna, hot tub, antibiotics, any sun sensitizing drugs. _____ Initial

I have been informed and advised to apply sunscreen daily of an SPF of 25 or higher and to use Hydroquinone to prevent any undesired results. _____ Initial

I promise to notify BBA of any and all changes in my medication, prescriptions, skincare regimen and treatments received outside of BBA. _____ Initial

I acknowledge and accept the risks inherent in the above-described procedures, including Laser Treatments and Beauty Procedures. I voluntarily assume the risk of injury, accident or death, which may arise from the Laser Treatments or the Beauty Procedures set forth herein; and any of my heirs, executors, representatives or assigns hereby release BBA from any and all claims, liabilities for personal injury, and property damages of any kind sustained while on the premises, during the treatments set forth herein by any employees, independent contractors or representatives of BBA. _____ Initial

I agree that this Acknowledgment, Consent and Waiver is in effect for the period of time I am obtaining the procedures identified on the first page of this Agreement.
If I am still receiving procedures from BBA in one year, I acknowledge that I will execute another Acknowledgment, Consent and Waiver form at that time. _____ Initial

COMPLICATIONS

If you experience complications of any type after your procedure, you are directed to contact: Alethea Tinkle Laser Specialist

Client Signature: _____

Date: _____

Important Note:

Bella / BBA does not provide medical advice or treatment. The use of Laser Treatments, Beauty Procedures may or may not be appropriate for you. Please consult your health care provider for medical advice. The information provided is for general information purposes only and does not address individual circumstances or medical conditions.

We look forward to seeing you!