CLIENT INFORMATION & MEDICAL HISTORY

All information is strictly confidential.

PERSONAL HISTORY

Client Name_____

Today's Date_____

Date of Birth _____Occupation _____

Home Address_____ City_____ State_____ Zip_____

Home Phone ( )_____ Cell ( )_____

Email_____

How were you referred to us? **_____**

Which of the following best describes your skin type? (Please circle one Skin type number)

I. White, Always burns, never tans

II. Cream, Always burns, sometimes tans

III. Light Tan, Sometimes burns, always tans

IV. Tan, Rarely burns, always tans

V. Brown, rarely burns in the sun

VI. Black, never burns in the sun

MEDICAL HISTORY

Are you currently under the care of a physician? __Yes __No

If yes, for what: _____

Are you currently under the care of a dermatologist? __Yes __No

If yes, for what? _____

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

__Cancer __Diabetes __High blood pressure __Herpes ___

__Frequent cold sores __HIV/AIDS __Keloid scarring __Skin disease/Skin lesions

__Seizure disorder __Hepatitis __Hormone imbalance __Thyroid imbalance __Blood clotting abnormalities

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) __Latex __Aspirin __Lidocaine __Hydrocortisone __Hydroquinone __Others:

MEDICATIONS

What oral medications are you presently taking? __Birth control pills __Hormones

__Others

(Please list):_____
Have you ever used Accutane? __Yes __No. If yes, when did you last use it? _____
What topical medications or creams are you currently using? __ RetinA , __Others: _____

SKIN CARE HISTORY

Do you have any skin sensetivities/allergies ___Yes ___No Describe:_____
Have you had any recent tanning or sun exposure that changed the color of your skin? __Yes __No
Do you form thick or raised scars from cuts or burns? __Yes __No
Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? __Yes __No Describe:_____

For our female clients:
Are you pregnant or trying to become pregnant? __Yes __No
I certify that the preceding medical, personal and skin history statements are true and correct.

Late cancellation/No Show/No Refunds 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.

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 hour 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, Inc. 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: _____ Date:_____

ACKNOWLEDGMENT, WAIVER AND CONSENT TO RECEIVE SKINCARE, LASER, AND DIAGNOSTIC PROCEDURES:

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, its providers, directors, agents, contractors, and employees to perform such procedures _____(initials)

LASER TREATMENTS:

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:(a) burning, blistering, scabbing, scars, hyper/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 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)**

(b) Despite these risks, I hereby authorize BBA to perform the above-described procedures. 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. 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 PROCEDURES AND PRODUCTS:"Beauty Procedures" include: Facials, Microdermabrasion, Laser Skincare, Body Contouring, and Injections. The material risks associated with these Beauty Procedures includes but not limited to: 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. **____(initials)**
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 **____(initials)**
I promise to notify BBA of any and all changes in my medication, prescriptions, skincare regimen and treatments received outside of BBA. **____(initials)**
I acknowledge and voluntarily accept and assume the risks which
may arise from the Laser Treatments or the Beauty Procedures set forth herein and 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.

I understand that there are no guarantees of results with Laser and Skincare procedures performed and provided by BBA and it's employees. _____ (initial)

No Returns or Refunds

Name:_____

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. Results are not guaranteed. 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.

Bella Monthly Memberships!

Be Confident Laser Hair Removal Membership $189/month
Value: $375

Be Radiant Anti-Aging Laser Membership $289/month
Value: $525