Client Intake Form
LED LIGHT THERAPY

Glitterella Smile
EMAIL: contactus@glitterellasmile.com
WEB:www.glitterellasmile.com

GENERAL INFORMATION

Name _____ Date of Birth _____

Address _____

City _____ Provence _____ Postal Code _____

Phone # _____ Email _____

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? _____

This form is designed to help assess your skin type and your needs and expectations of the LED Light Therapy treatment.

1. Client skin type _____

Skin type	Complexion	Description
• Type 1	Very pale	always burns, never tans
• Type 2	Fair	skin and hair burns easily, tans minimally
• Type 3	Slightly darker	skin burns sometimes, tans gradually
• Type 4	Mediterranean	burns rarely, tans easily
• Type 5	Asian/Arabic	burns rarely, always tans
• Type 6	Afro-Caribbean	never burns, always tans

2. Which skin care products do you use...
a. On The Face? _____
b. On The Neck? _____
c. Do you regularly use a face cream with an SPF? Y/N
3. Have you undergone any cosmetic/aesthetic treatments in the last 24 hours? Y/N If YES please list
_____
4. Are you currently undergoing any other aesthetic treatments? Y/N If YES please list
_____
5. Do you use sunbeds or are regularly exposed to sun? Y/N
6. Do you smoke? Y/N
7. What are your primary skin concerns?
_____ 8. What are your goals and expectations of the treatment? _____

Treatment type:
Anti-Ageing/Acne
BlemishProne/Skin
Post Treatment
Other: _____

Cient Signature _____ Date _____

LED LIGHT THERAPY TREATMENT CONSENT FORM & LIABILITY WAIVER

What is LED Light Therapy

LED Light Therapy is a non-invasive form of phototherapy that takes advantage of the essential wavelength spectrum optimized for light to penetrate deep into the body. This light stimulates cellular repair and skin regeneration, helping to rejuvenate skin and release toxins from cells.

How it works

LED Light Therapy uses varying wavelengths of light to help regenerate the skin and increase the healing process. Low-wattage light is directed through the skin's epidermis and aimed at fibroblast cells, which produce collagen and elastin. The light stimulates the cell's own energy transport system, helping nurture and renew the skin.

What you can expect

- LED Light Therapy is a painless procedure, after treatment, you may feel slightly warm.
- During the application, you may feel a sense of warmth, like you would if you were sitting in the sun.
- The procedure doesn't require any recovery time. Typically, you can get back to your daily routine right after the treatment.

Before and aftercare

Before the treatment, you are not required to do anything special, however, keeping your body well-hydrated is strongly recommended. After treatment is recommended you avoid sun exposure and apply sunscreen for 2-3 days.

How many treatments?

Results are cumulative. 8-10 treatments spaced 1-2 weeks apart are recommended for optimal results. During your consultation, our specialist will work with you to develop a tailored treatment plan, to achieve the best possible results for your concerns. We will use our experience and expertise to be able to provide you with the closest guide possible when advising the number of sessions required.

Please note, results will vary client to client due to age, lifestyle and condition of the skin. Some clients see results a lot quicker than others however this again will vary person to person. Please be patient, we are just as excited about seeing the results as you are.

LED LIGHT THERAPY TREATMENT CONSENT FORM & LIABILITY WAIVER

Do you have any of the following?

- Pregnant or breastfeeding. Yes/No
- Isotretinoin (Accutane, Roaccutane) or other similar medication. Yes/No
- Tretinoin (Retin-A, Retinol). Yes/No
- St John's Wort. Yes/No
- Epilepsy or seizure disorders. Yes/No
- Autoimmune and metabolic disorders. Yes/No
- Acute inflammatory processes or skin conditions. Yes/No
- Anti-arthritic medication (Azathioprine). Yes/No
- Open wounds or recent surgeries in the treatment area. Yes/No
- Light-induced migraines. Yes/No
- Photosensitivity. Yes/No
- Active skin infections. Yes/No

If you answer YES to any of these questions, please specify:_____

_____

Pictures may be obtained for clinical records. If pictures are used for education or marketing purposes, all identifying marks will be cropped or removed. Initial:_____

By signing below, I agree that 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 these treatments. I do not hold the technician, whose signature appears below, or responsible for any of my conditions that were present, but not disclosed at the time of this procedure, which may be affected by the treatment performed today.

Printed Name	Signature	Date
_____	_____	_____
Technician Name	Signature	Date
_____	_____	_____

PHOTO & VIDEO RELEASE FORM

I,_____ hereby grant and authorize Glitterella Smile the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures, video, and/or audio 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 media 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 and later discovered.

I will be consulted about the use of the photograph and/or video recording for any purpose other than those listed below:

- PROMOTIONAL MATERIALS.
- PRINTED AND/OR DIGITAL.
- EDUCATIONAL PRESENTATIONS OR COURSES.
- INFORMATIONAL PRESENTATIONS.
- ONLINE EDUCATIONAL COURSES.
- EDUCATIONAL VIDEOS.
- SOCIAL MEDIA POSTS.

There is no time limit on the validity of this release nor is there any geographical limitation on where these materials may be distributed.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material for educational purposes.

DATE:_____

CLIENT FULL NAME:_____

GLIENT SIGNATURE:_____

CANCELLATION FORM

Dear Client,

We strive to render excellent care to you and the rest of our clients. Your care and treatment is a priority for us. We also ask that you respect your specialist's time and expertise as well.

In an attempt to be consistent with this, we have a Cancellation Policy that allows us to schedule appointments for our clients, with respect for your time, the next client's time, and the specialist's time.

Our policy is as follows:

We request that you give a notice not later than 24 hours prior to your scheduled appointment in the event that you cannot make it. If the client misses an appointment without contacting us, it is considered a missed or "No Show" appointment. Additionally, if a client is more than 15 minutes late for an appointment, it will be considered a "No Show" appointment, and that appointment will be rescheduled.

A $15.00 non refundable deposit will be paid at the time of making an appointment and will be taken off at the time of the appointment.

If you have questions regarding this policy, please let us know, and we will be happy to clarify our policy for you

I have read and understand the Appointment Cancellation Policy, and I agree to be bound by its terms. I am aware that my credit card will be charged for the missed appointment, and I agree to these terms.

I_____, have received the copy of Cancellation Policy

Date:_____

Client Name(Printed):_____

Client Signature:_____