Client Intake Form
PARIFFIN TREATMENT

Glitterella Smile
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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? _____

HISTORY

For over 90 years paraffin moist heat therapy has been used to relieve pain, inflammation and stiffness caused by arthritis. Warm paraffin is also used extensively to soften dry, cracked skin by drawing moisture from within the body to the surface. Paraffin acts like a form of heat therapy and can help increase blood flow, relax muscles, and decrease joint stiffness. Paraffin wax can also minimize muscle spasms and inflammation as well as treats sprains.

It is completely natural and has a low melting point, which means it can be easily applied to the skin at a temperature low enough not to cause burns or blisters.

However, if you have very sensitive skin, paraffin wax may cause heat rash. Heat rash results in small red bumps on the skin that can be itchy and uncomfortable. You may develop minor swelling or breakouts from the wax treatment.

You should not use paraffin wax if you have:

- poor blood circulation
- numbness in your hands or feet
- diabetes
- any rashes or open sores
- chemical sensitivity
- allergy to petroleum-based products

By my signature below, I certify that I have read and fully understand the contents of this consent form. I was given the opportunity to ask any questions or clarification I might have prior to signing this consent and thereby grant permission to perform this procedure on me.

Cient Signature _____ Date _____

continued on reverse

Please read and initial.

I declare I do not suffer from any of the below conditions

_____ poor blood circulation
_____ numbness in your hands or feet
_____ diabetes
_____ any rashes or open sores
_____ chemical sensitivity
_____ allergy to petroleum-based products

Client Consent:

1. I have read and initialled this consent form and understand the risks and benefits explained on it. I understand it is impossible to state every risk or complication that may occur but the technician has answered all my questions to my satisfaction.
2. I have had the opportunity to ask questions regarding this procedure.
3. I consent to treatment and I assume all responsibility for the risks described above.
4. All information I have given is truthful.

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:_____