CLIENT AGREEMENT & LIABILITY WAIVER

CLIENT INFORMATION:

FIRST NAME:	LAST NAME:	DATE:
ADDRESS:	CITY & STATE:	ZIP CODE:
PHONE NUMBER:	ALT. PHONE NUMBER:	EMAIL ADDRESS:
REFERRED BY: DOCTOR / FRIEND / OTHER (LIST)		EMPLOYER:
PROFESSION:	MEDICATIONS (INCLUDING HERBS):	
CURRENT SKIN CARE PRODUCTS:		

MEDICAL HISTORY (Select all that apply):

☐ Asthma/Difficulty Breathing
☐ Bruises Easily
☐ Bleeding Disorder, Anemia, Bleeding Tendency
☐ Cardiovascular Disease
☐ Skin or Nail Infections
☐ Cold Sores / Shingles / Herpes
☐ HIV/Aids
☐ Sexually Transmitted Disease
☐ Smoker
☐ Strokers
☐ Eye Disease / Glaucoma
☐ Pacemaker / Metal Implant
☐ Depressions
☐ Anxiety / Panic Disorder
☐ Diabetes
☐ Low Blood Sugar
☐ Thyroid Disorder
☐ Kidney Disease
☐ Heart Disease
☐ Radiation (X-Ray) Treatment For Cancer
☐ Seizures
☐ Fibromyalgia
☐ High / Low Blood Pressure
☐ Neck / Back Pain
☐ Neuro-Muscular Disease
☐ Other _____

ALLERGIES (List All):

_____

_____

_____

PLEASE ANSWER YES OR NO:

Smoke or chew tobacco? | Packs Per Day _____
☐ Y ☐ N

History of Alcohol or Chemical Dependency?
☐ Y ☐ N

History of mental illness or emotional disorders?
☐ Y ☐ N

USING ANY OF THE FOLLOWING?

☐ Antibiotics _____
☐ Anticoagulants (Blood Thinners) _____
☐ Aspirin, or drugs such as: Motrin, Aleve, Ibuprofen
☐ Blood Pressure Medications _____
☐ Steroids (Cortisone, Prednisone, etc.) _____
☐ Retin-A or Topical Retinoids _____

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FAMILY HISTORY (Select all that apply):

☐ Alcoholism
☐ Asthma
☐ Epilepsy
☐ Stroke
☐ Mental Illness
☐ Obesity
☐ Allergies
☐ Ulcers
☐ Birth Defects
☐ Hearing Loss
☐ Migraine
☐ Cancer
☐ Osteoporosis
☐ Heart Disease
☐ Miscarriage
☐ Arthritis
☐ Alzheimer's Disease
☐ Kidney Disease
☐ High Blood Pressure
☐ Muscular Dystrophy
☐ Anesthetic Problems
☐ Cystic Fibrosis
☐ Diabetes
☐ Other _____

WOMEN ONLY (Select all that apply):

Are you pregnant or a chance you may be?
☐Y ☐N

Are you nursing?
☐Y ☐N

SKIN HISTORY (Select all that apply):

☐ Excess Pigment / Freckles
☐ Lack of Pigment
☐ Eczema, Psoriasis, or Rashes
☐ Thick / Keloid Scars
☐ Skin Reaction to Treatments
☐ Melasma / Mask of Pregnancy
☐ Acne / Cystic Acne
☐ Skin Cancer
☐ Accutane (When: _____)
☐ Rosacea
☐ Broken Capillaries

PREVIOUS TREATMENTS (Select any that you have had):

☐ Botox / Dysport
☐ Fillers
☐ Chemical Peel
☐ Intense Pulsed Light Therapy
☐ Micro-Needling
☐ Laser Hair Reduction
☐ Laser Vein Reduction
☐ Microdermabrasion
☐ Retina-A or Topical Treatments
☐ Permanent Makeup

CHECK THE FOLLOWING TREATMENTS YOU ARE INTERESTED IN LEARNING MORE ABOUT:

☐ Fillers
☐ Botox / Dysport
☐ Dermaplaning
☐ Laser Hair Reduction
☐ Laser Vein Reduction
☐ Laser Genesis
☐ Facials
☐ Makeup
☐ Chemical Peels
☐ Intense Pulsed Light Therapy
☐ Products
☐ Waxing
☐ Microdermabrasion
☐ Micro-Needling
☐ Cosmetic Surgery

CHECK THE FOLLOWING CONDITIONS THAT YOU WOULD LIKE TO CORRECT:

☐ Dryness
☐ Aging Spots / Sunspots
☐ Melasma
☐ Rough Skin Texture
☐ Enlarged Pores
☐ Acne
☐ Oily Skin
☐ Wrinkles
☐ Sagging Skin
☐ Other _____

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LIABILITY WAIVER

I _____, hereby certify and agree to as follows:

I accept full responsibility for my health and voluntarily agree to this acknowledgment and Waiver of Liability.

I certify that I am seeking the consultation and treatment services of Annie Pafford and Healthy Naturally You for alternative healing suggestions and therapies, which I fully understand are not medical diagnoses, treatments, or substitutes for medical diagnoses or treatments given by an actual Medical Doctor (MD).

I certify that with respect to any medical conditions or concerns I may have. I have been advised to consult with my personal healthcare physician and understand that Annie Pafford and Healthy Naturally You is NOT a primary care physician, and I am seeking analyses, and I do not view Annie Pafford or Healthy Naturally You as my medical office or physician. Annie Pafford and Health Naturally You specializes in a natural approach to healing, including, but not limited to, Nutrition and Energy Therapies.

I understand that Annie Pafford and Healthy Naturally You does not handle medical conditions and/or emergencies and does not maintain hospital privileges.

In seeking to become a client of Annie Pafford and Healthy Naturally You, I understand I am seeking analyses and/or therapies that may not be FDA registered or approved and may be considered experimental. These include but are not limited to: Photo Genie, Photon Genius, Rejuvenation, Detoxification, and Energy Balancing techniques.

I understand and agree that neither Annie Pafford nor Healthy Naturally You makes any claims whatsoever, either expressed or implied, regarding effects or outcomes of the analyses or therapies provided and shall not be liable for the above mentioned.

I certify that I seek the advice and treatment of Annie Pafford and Healthy Naturally You solely in my personal capacity, and do not represent any governmental agency, law firm, attorney, or investigator. I am not involved in a lawsuit nor am I gathering information for a potential lawsuit.

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I _____, understand the importance of a truthful and complete Health/Skin History to assist Annie Pafford and Healthy Naturally You in providing the best care possible. I have had the opportunity to discuss my Health/Skin History with Annie Pafford and Healthy Naturally You.

The practice of a medical spa is not exact science. Although good results are expected, there is not a guarantee nor warranty expressed or implied as to the results that may be obtained. There are variable conditions, risks, and potential complications that may influence long-term results from treatments. Annie Pafford and Healthy Naturally You may provide you with additional or different information that is based on all facts in your case or state of medical knowledge. Informed consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined based on the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and practice patterns evolve. With my consent, Annie Pafford and Healthy Naturally You may use or disclose protected health information about me to carry out treatment. You have the right to refuse to sign or revoke an authorization to disclose your protected health information. I authorize them to call or send mail to my designated location(s). I further understand that any changes in my health history should be updated immediately by me. I will Follow all pre and post care instructions for my treatments.

RF RADIO FREQUENCY TREATMENTS (ReFirme)

I _____, Consent to authorize Healthy Naturally You To perform any treatments on me. Light can be used to effectively destroy targets located within the skin with minimum damage to surrounding tissues. Light can be used to lighten, fade, or remove pigment or photo damaged skin in a non-ablative manner. Visible signs of photo damage include wrinkling, enlarged pores, course skin, and texture/pigment alterations.

Pigmentary changes, such as hyper pigmentation and Hypo Pigmentation in the treated area can occur. Mostly it is transient, lasting up to six months, but in rare cases can be permanent. Most cases of hypopigmentation occur in people with darker skin or when the treated area has been exposed to sunlight before & after treatment. Occasionally these pigmented changes occur despite protection from the sun.
Scarring, which can be hypertrophic or even keloid can occur. Other known complications of this procedure include, Blisters, reddening, pinpoint red scars, bruising,

superficial crusting, burns, pains, and infections. **These side effects are usually temporary, lasting from 5-10 days, but can be permanent as well.**

The skin at or near treatment site may become fragile. If this happens makeup should be avoided, and the area should not be rubbed as it could tear the skin. A blue purple bruise may appear on treated area, which may last from 5-30 days. As the bruise fades there may be a rusty/brown discoloration of the skin, which will fade in 1-4 months or longer.

ADDITIONALLY, hair-loss can occur on or around treated areas. In a very small percent of people, there is new hair growth surrounding the areas being treated.

Even though measures are taken to reduce side effects, the possibility of having them cannot be eliminated in every case.
I _____, understand that the treatment may involve risks and potential injury from both known and unknown causes, and I freely assume these risks. There may be other treatment options such as injections, LED Lights, and Peels. I am choosing this non- invasive treatment for vascular or pigmented legions, stretch marks, wrinkle reduction and other indicated skin conditions.

Eye damage can occur from the light and therefore protective eyewear must be worn during all photo therapy sessions.

I have READ and UNDERSTAND the pre and post treatment instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre, and post procedure guidelines, are crucial for healing, prevention of scaring, and other side effects such as Hyperpigmentation and hypopigmentation, along with other textural changes.

I understand this examination is not meant to replace the necessity for a complete derma examination.

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PHOTOGRAPHS - I Give permission for my photographs to be used to help document my treatment course. Complete confidentiality will be maintained. **Y / N** (circle one)

SESSION PAUSES – In the event that a client needs to break away from their personalized treatment schedule (i.e., 3X/Week), their time that has already been paid for will be paused until the client is ready to resume treatments. For further clarification, if a 6-month or 12-month package is purchased, and the client needs a break due to any reason after the second month of treatments, their purchased package will have 4 or 12 months remaining when they wish to resume treatment.

In Absence of Annie Pafford – If Annie Pafford needs to miss any time during scheduled treatments with clients, those clients will either be designated as Self-Serve Clients, or arrangements for another employee to be present to guide the treatment will be arranged.

No guarantee, warranty, or assurance has been made to me that results will be obtained. I am aware that follow-up appointments may be necessary for desired results. Most patients require several treatments with gradual results over time. **NO REFUNDS** will be given for treatments received and I agree to adhere to all safety precautions and regulations during the treatment process. The nature and purpose of said treatments have been explained to me. I have read and understand this agreement. All my questions have been answered to my satisfaction, and I consent to the terms of the agreement. Alternative methods of treatment, their risks, and benefits have been explained to me and I understand I have the right to refuse treatment.

I release Annie Pafford Healthy Naturally You, and all staff from liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age. This consent is freely and voluntarily executed, and shall be binding upon my spouse, relatives, legal representatives, heirs, administers, and successors.

NOTE* - ALL PRICES ARE SUBJECT TO CHANGE

By signing below, the client also agrees to the above written Terms & Conditions as well.

_____ _____

CLIENT SIGNATURE DATE

10425 N Oracle – Ste 125
Oro Valley, AZ 85737

269-330-6847

HealthyNaturallyYou11@gmail.com

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Waiver and Release of Liability – Piezo Wave 2

In agreeing to utilize "PiezoWave2T (Class 1 - FDA registered acoustic pulse application technology) provided by Healthy Naturally You, LLC ("HNY") I agree as follows:

I fully understand and acknowledge that (a) the activities I will engage in as part of the PiezoWave2T provided by HNY and the equipment I may utilize as a part of the use have inherent risks, dangers and hazards as such exist in my participation of use; (b) my participation in such use may result in injury, disease, strains, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; (c) these risks and dangers may be caused by the negligence of the representatives or employees of HNY the negligence of the participants, the negligence of others, accidents, breaches of contract, or other causes. By my participation in these activities and for use of PiezoWave2T, I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the owners, representatives or employees of HNY or by any other person.

I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify, HNY and their owners, representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims or actions that I may have presently or in the future for negligent acts or other conduct by the owners, representatives, or employees of HNY.

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT AGREE. IT IS MY INTENTION TO EXEMPT AND RELIEVE MACSONS DME LLC FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH CAUSED BY NEGLIGENCE OR ANY OTHER CAUSE.

Name (print) _____ **Date of birth** ____/_____/_____

Address _____ **City** _____ **State** ____ **Zip**_____

Phone_____ **Email** _____

Signature _____**Date** ____/_____/_____

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HEALTHY NATURALLY You!

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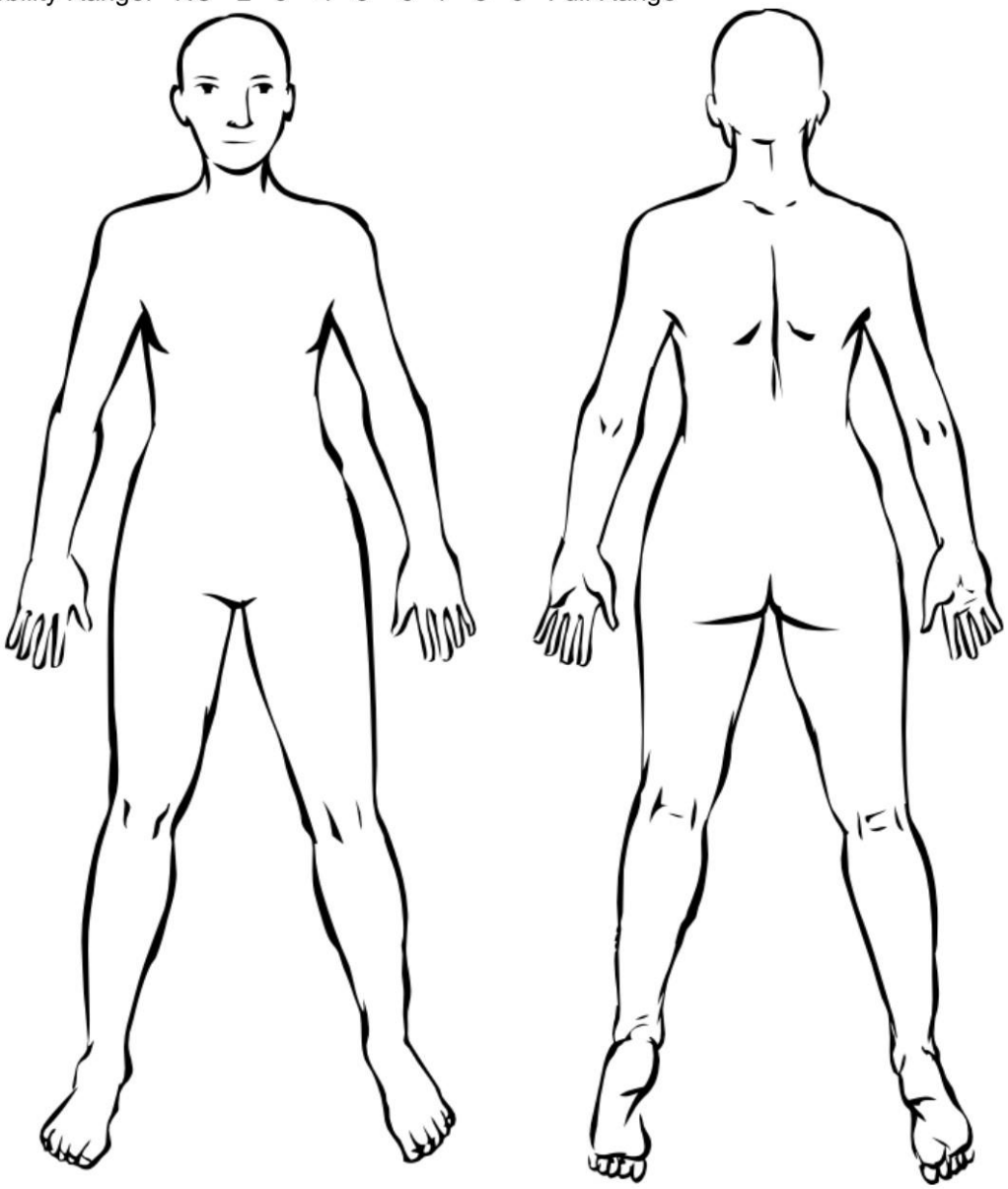
Date or Onset of pain/injury: _____/_____/_____
Previous Treatment:_____
Average (PL) Pain Level: 1 2 3 4 5 6 7 8 9 10
Mobility Range: NO 2 3 4 5 6 7 8 9 Full Range



Additional Comments:_____
_____
_____

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Notes

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