SUBTAB: VACUUM THERAPY CONSENT FORM:

adoRN Esthetics, LLC

VACUUM THERAPY CONSENT FORM

1) Prior to receiving this treatment, I have been candid in revealing any condition that may have a bearing on this procedure, such as: pregnancy, recent facial peels or surgery, allergies, tendencies to cold sores and fever blisters, Use of Retin-A, Glycolic Acids, Accutane, Hormonal Therapy Anticoagulants (Blood Thinners) and Aspirin.

2) I understand there are no guarantees to this procedure.

3) I understand that while butt vacuum therapy is **generally considered safe**, there are some risks and side effects to be aware of. These can include: Bruising and swelling: The vacuum suction device used in the procedure can cause bruising and swelling in the treated area. This is usually temporary and should subside within a few days.

4) I understand that to achieve maximum results, I will need several ongoing treatments and will need to use daily products to heal and protect my skin.

5) I understand that the possibility of irritation and redness exists and that I should notify my skin care professional if irritation persists.

6) I will follow the home care program specifically designed for me without changing or adding any products without consulting with my skin care professional.

7) I agree to all of the above to have this treatment performed on me and will follow all prescribed directions regarding post treatment care.

PRINT NAME: _____
SIGNATURE: _____
DATE: _____