

AESTHETIC GLOW EXPERIENCE

Client Agreement & Policies

CLIENT AGREEMENT

I understand that Aesthetic Glow Experience provides cosmetic skincare and wellness services and that treatments are intended to support the appearance and overall condition of the skin.

I understand that services are not intended to diagnose, treat, or cure medical conditions.

I agree to provide truthful and complete information regarding my health, skincare history, medications, allergies, and recent cosmetic treatments.

APPOINTMENTS

Clients are encouraged to arrive on time for their scheduled appointment. Arriving late may reduce treatment time in order to accommodate the next scheduled client.

Appointments may be subject to cancellation or rescheduling policies established by Aesthetic Glow Experience.

CANCELLATION / NO-SHOW POLICY

Cancellation or rescheduling requests should be made at least _____ hours before the scheduled appointment.

Late cancellations and no-shows may result in:

- ☐ Cancellation fee of \$ _____
 - ☐ Loss of deposit
 - ☐ Other:
-

PAYMENT

Payment is due at the time of service unless otherwise agreed upon.

Accepted payment methods:

- ☐ Credit / Debit
 - ☐ Cash
 - ☐ Other:
-

All purchases, memberships, packages, and gift cards are subject to the terms provided at the time of purchase.

HOME CARE

I understand that proper home skincare and following post-treatment instructions are important for maintaining and supporting treatment results.

I agree to follow the aftercare instructions provided to me.

I understand that failure to follow recommended aftercare may increase the possibility of irritation or unwanted reactions.

PHOTOGRAPHY & MARKETING CONSENT

Aesthetic Glow Experience may request before-and-after photographs to document treatment progress.

Please select one:

- ☐ I give permission for my photographs to be used for educational, promotional, website, and social media purposes.
- ☐ I consent to photographs being taken for my private treatment records only.
- ☐ I do not consent to photographs being taken.

I understand that marketing use is voluntary and that my decision will not affect the quality of services I receive.

ACKNOWLEDGMENT

By signing below, I acknowledge that I have read and understand the Client Agreement, Facial Consent, and applicable policies. I have had the opportunity to ask questions and agree to provide accurate information before receiving services.

Client Name:

Client Signature:

Date: _____

Esthetician Signature:

Date: _____

FOR OFFICE USE ONLY

Treatment Performed:

Products / Peels Used:

Skin Observations:

Home Care Recommendations:

Follow-Up Recommended:

Next Appointment:

AESTHETIC GLOW EXPERIENCE

Skincare Client Intake Form

Client Information

Full Name:

Date of Birth: _____ Phone:

Email:

Address:

Emergency Contact: _____ Phone:

SKINCARE CONCERNS

What are your primary skincare concerns?

- ☐ Acne / Breakouts
- ☐ Blackheads / Congestion
- ☐ Dryness / Dehydration
- ☐ Oily Skin
- ☐ Sensitive Skin
- ☐ Hyperpigmentation / Dark Spots
- ☐ Fine Lines / Wrinkles
- ☐ Dullness / Uneven Skin Tone
- ☐ Redness
- ☐ Puffiness
- ☐ Loss of Firmness
- ☐ Scarring
- ☐ Other:

What would you like to improve about your skin?

CURRENT SKINCARE ROUTINE

What products are you currently using?

Cleanser:

Serum(s):

Moisturizer:

Exfoliants / Acids:

Retinol / Retinoids:

Sunscreen:

Other:

PROFESSIONAL SKINCARE HISTORY

Have you had a professional facial before?

☐ Yes ☐ No

When was your most recent facial?

Have you had any of the following within the past 4 weeks?

- ☐ Chemical peel
 - ☐ Microneedling
 - ☐ Laser treatment
 - ☐ Waxing / threading
 - ☐ Injectables
 - ☐ Dermaplaning
 - ☐ Other:
-

Date of most recent treatment:

MEDICAL & SKIN HEALTH INFORMATION

Please check any that apply:

- ☐ Pregnancy / breastfeeding
- ☐ Allergies or known sensitivities
- ☐ Active cold sore / fever blister

- ☐ Eczema / dermatitis
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Active skin infection
- ☐ Open wounds / broken skin
- ☐ Severe or inflamed acne
- ☐ Recent sunburn
- ☐ History of abnormal scarring / keloids
- ☐ Diabetes
- ☐ Autoimmune condition
- ☐ Blood-thinning medication
- ☐ Other medical condition relevant to skincare

Please explain anything checked above:

Are you currently taking any medications?

- ☐ Yes ☐ No

If yes, please list:

ALLERGIES

Do you have any known allergies to skincare ingredients, medications, latex, fragrances, or other substances?

- ☐ Yes ☐ No

If yes, please explain:

LIFESTYLE

Do you regularly use:

- ☐ Tanning beds
- ☐ Self-tanner
- ☐ Cigarettes / nicotine
- ☐ Alcohol
- ☐ Recreational substances

Average daily water intake:

How often do you wear sunscreen?

- ☐ Daily ☐ Occasionally ☐ Rarely ☐ Never

CLIENT GOALS

What is your main skincare goal over the next 1–3 months?

How did you hear about Aesthetic Glow Experience?

- ☐ Instagram
- ☐ Facebook
- ☐ Google
- ☐ Referral
- ☐ Friend / Family

☐ Other:

I confirm that the information provided above is accurate and complete to the best of my knowledge.

Client Signature:

Date: _____

AESTHETIC GLOW EXPERIENCE

Facial Consent & Treatment Agreement

Client Name:

Date: _____

INFORMED CONSENT

I understand that facial and skincare treatments are cosmetic services intended to improve the appearance and condition of the skin. Results vary from person to person and are not guaranteed.

Depending on the treatment selected, services may include cleansing, exfoliation, steam, extractions, facial massage, masks, serums, LED therapy, oxygen infusion, lymphatic techniques, superficial exfoliating treatments, and other non-invasive skincare procedures appropriate for my skin.

I understand that temporary reactions may occur, including:

- Redness
- Mild swelling or puffiness
- Tingling or warmth
- Temporary sensitivity
- Dryness or flaking
- Mild irritation
- Temporary breakouts
- Bruising or tenderness when applicable
- Increased sensitivity to sunlight

I understand that more intensive exfoliation or peel services may result in additional redness, peeling, dryness, or sensitivity.

CLIENT RESPONSIBILITIES

I agree to provide complete and accurate information regarding my health, medications, allergies, skincare products, previous treatments, and any conditions that may affect my treatment.

I understand that I must inform my skincare professional of any changes to my health or skincare routine before receiving treatment.

I agree to disclose any recent:

- ☐ Chemical peels
- ☐ Laser treatments
- ☐ Microneedling
- ☐ Injectables
- ☐ Waxing / threading
- ☐ Sun exposure / sunburn
- ☐ Other professional treatments

I understand that certain conditions or circumstances may require my treatment to be postponed or modified for my safety.

PRODUCT & INGREDIENT CONSENT

I understand that professional skincare products and ingredients may be applied to my skin during treatment. I agree to inform my skincare professional of any known allergies, sensitivities, or previous reactions.

I understand that a patch test may be recommended when appropriate.

RESULTS

I understand that individual results vary and depend on factors including skin condition, lifestyle, home skincare, sun exposure, consistency, and individual response to treatment.

No specific result or outcome has been guaranteed to me.

RIGHT TO STOP TREATMENT

I understand that I may communicate discomfort at any time and may request that treatment be modified or stopped.

The skincare professional may also discontinue or modify treatment if they determine that continuing is not appropriate for my skin or safety.

CONSENT

By signing below, I confirm that I have read and understood this consent form, have had the opportunity to ask questions, and voluntarily consent to receive the selected skincare treatment.

Client Name:

Client Signature:

Date: _____

Esthetician:

Treatment:

—

Treatment Date:

AESTHETIC GLOW EXPERIENCE

Cryotherapy Consent Form & Client Agreement

CLIENT INFORMATION

Client Name:

Date of Birth: _____ Phone:

Email:

Emergency Contact: _____ Phone: _____

Treatment Date: _____ Provider: _____

TREATMENT DESCRIPTION

I understand that cryotherapy is a cosmetic treatment that uses controlled cold temperatures on selected areas of the body. Depending on the service provided, cryotherapy may be used for cosmetic skin concerns, localized wellness services, or other non-invasive purposes.

I understand that the treatment may involve exposure to cold air, cold surfaces, cooling devices, or other cryotherapy equipment. The treatment area may experience temporary coldness, numbness, tingling, redness, swelling, or sensitivity.

I understand that cryotherapy is not intended to diagnose, treat, or cure any medical condition and is not a substitute for medical care.

HEALTH SCREENING

Please check any that apply:

- ☐ Pregnancy or breastfeeding
- ☐ Cold allergy or cold urticaria
- ☐ Raynaud's disease or phenomenon

- ☐ Poor circulation or peripheral vascular disease
- ☐ Uncontrolled high or low blood pressure
- ☐ Heart disease or cardiovascular condition
- ☐ History of stroke or blood clots
- ☐ Deep vein thrombosis or pulmonary embolism
- ☐ Diabetes or impaired sensation
- ☐ Neuropathy or reduced ability to feel temperature
- ☐ Open wounds, cuts, sores, or active skin infection
- ☐ Eczema, psoriasis, dermatitis, or other active skin condition
- ☐ Severe or uncontrolled asthma
- ☐ Seizure disorder
- ☐ Kidney or liver disease
- ☐ Cancer or current cancer treatment
- ☐ Recent surgery or medical procedure
- ☐ Current illness, fever, or infection
- ☐ Use of blood-thinning medication
- ☐ Use of medication that affects circulation or sensation
- ☐ History of abnormal scarring or keloids
- ☐ Other medical condition:

Please explain anything checked above:

Are you currently taking any medications or supplements?

☐ Yes ☐ No

If yes, please list:

Do you have any known allergies or sensitivities?

☐ Yes ☐ No

If yes, please explain:

CONTRAINDICATIONS AND DISCLOSURE

I understand that cryotherapy may not be appropriate for individuals with certain medical conditions, medications, skin conditions, circulation concerns, or impaired sensation.

I agree to notify Aesthetic Glow Experience before treatment if I develop any new medical condition, illness, injury, skin irritation, medication change, pregnancy, or other circumstance that may affect my eligibility for cryotherapy.

I understand that the provider may postpone, modify, or decline treatment if it is determined that the service may not be appropriate or safe for me.

POSSIBLE RISKS AND SIDE EFFECTS

I understand that possible temporary effects may include:

- Coldness, numbness, tingling, or stinging
- Redness or temporary discoloration
- Mild swelling or puffiness
- Dryness, irritation, or sensitivity
- Itching or discomfort
- Temporary tenderness
- Headache, lightheadedness, or feeling faint
- Temporary changes in skin sensation
- Skin blistering, burns, frostbite, or tissue injury in rare cases
- Worsening of an existing skin condition
- Allergic or cold-related reaction
- Other unexpected or delayed reaction

I understand that individual responses vary and that no specific result is guaranteed.

TREATMENT SAFETY

I agree to communicate immediately if I experience excessive cold, pain, burning, dizziness, shortness of breath, chest discomfort, severe numbness, unusual skin color changes, or any other concerning symptom during treatment.

I understand that I may request that treatment be stopped at any time.

The provider may stop treatment immediately if a safety concern arises.

I understand that protective clothing, coverings, or other safety measures may be required depending on the treatment area and equipment used.

AFTERCARE INSTRUCTIONS

I agree to follow all aftercare instructions provided by Aesthetic Glow Experience.

After treatment, I understand that I may be advised to:

- Keep the treated area clean and protected
- Avoid excessive heat, hot tubs, saunas, and strenuous activity for the period recommended
- Avoid rubbing, scratching, or applying irritating products to the treated area
- Avoid sun exposure and use appropriate sun protection

- Avoid additional cosmetic or medical treatments until cleared by the provider
- Contact a medical professional if I experience severe pain, blistering, spreading redness, significant swelling, loss of sensation, or other concerning symptoms

I understand that failure to follow aftercare instructions may increase the risk of irritation, injury, or unwanted reactions.

MEDICAL CARE

I understand that Aesthetic Glow Experience and its providers do not provide emergency or medical care through this service.

If I experience a serious or concerning reaction, I agree to seek appropriate medical attention promptly. In an emergency, I understand that I should call emergency services.

PHOTOGRAPHY & MARKETING CONSENT

Aesthetic Glow Experience may request before-and-after photographs to document treatment progress.

Please select one:

☐ I give permission for my photographs to be used for educational, promotional, website, and social media purposes.

☐ I consent to photographs being taken for my private treatment records only.

☐ I do not consent to photographs being taken.

I understand that marketing consent is voluntary and that my decision will not affect the quality of services I receive.

CLIENT AGREEMENT

I confirm that I have provided complete and accurate information regarding my health, medications, allergies, skin condition, and medical history.

I understand the nature and purpose of cryotherapy, including its potential benefits, limitations, risks, and possible side effects.

I understand that results vary and that no specific outcome has been promised or guaranteed.

I have had the opportunity to ask questions, and my questions have been answered to my satisfaction.

I voluntarily consent to receive cryotherapy from Aesthetic Glow Experience.

APPOINTMENTS, CANCELLATIONS, AND PAYMENT

Clients are encouraged to arrive on time for scheduled appointments. Arriving late may reduce treatment time in order to accommodate the next scheduled client.

Cancellation or rescheduling requests should be made at least _____ hours before the scheduled appointment.

Late cancellations and no-shows may result in:

- ☐ Cancellation fee of \$ _____
 - ☐ Loss of deposit
 - ☐ Other:
-

Payment is due at the time of service unless otherwise agreed upon.

Accepted payment methods:

- ☐ Credit / Debit
 - ☐ Cash
 - ☐ Other:
-

All purchases, memberships, packages, and gift cards are subject to the terms provided at the time of purchase.

ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have read and understood this Cryotherapy Consent Form and Client Agreement. I confirm that the information I provided is accurate and complete. I understand that I may withdraw consent before treatment begins and may request that treatment be stopped during the service.

Client Name:

Client Signature:

Date: _____

Provider Signature:

Date: _____

Parent or Legal Guardian Name, if applicable:

Parent or Legal Guardian Signature:

Date: _____

FOR OFFICE USE ONLY

Treatment Performed:

Treatment Area:

Equipment or Device Used:

Temperature or Setting, if applicable:

Treatment Duration:

Skin Condition Before Treatment:

Client Response During Treatment:

Skin Condition After Treatment:

Adverse Reaction or Incident:

☐ No

☐ Yes — describe:

Aftercare Instructions Provided:

Follow-Up Recommended:

Next Appointment:

Provider Notes: