

BEAUTY/SPA PROGRAM LASER/RADIO FREQUENCY SUPPLEMENT

Confirm all laser services and applications offered (ie.Laser, Pulse Light or Radio Frequency):

Hair Removal	Acne Scarring	Wrinkles	Large Pores
Fine Lines	Hyperpigmentation	Loose Skin	Vascular Lesions
Rough Texture	Tattoo Removal	Skin Resurfacing	Other:

Please advise if Other:

Are the treatments/procedures: Invasive/Ablative Fractional Non-Invasive/Non-Ablative

Names of People Providing Laser Treatments	Years of Education	Years of Experience	Any prior claims against individual, details

Complete this section for all laser machines, if hand pieces please list these separately

Make	Model	Age	Replacement Cost

Hand devises used: _____

ADDITIONAL INFORMATION:

Gross Receipts from laser treatments? \$ _____

Confirm minimum age of clients is 18 for laser services Yes No Other, specify: _____

Is a patch test completed 24 or more hours prior to laser treatments? _____

How often do you calibrate your machines? _____

Does client wear protective eyewear during procedures? _____ Do you wear surgical gloves? _____

Do you keep copies of clients service records? Yes No If yes, for how many years? _____

Is a waiver signed? Yes No Please attach copy for our file. How many years are the waivers kept? _____

What precare information do you provide clients? _____

What post care information do you provide clients? _____

Do you provide any off site laser treatments? Yes No If yes, please describe locations, methods, frequency, _____

**** IF OFFERING TATTOO REMOVAL** Advise Maximum size per any one appointment i.e. 2" x 2"**