SUGARED
Beauty Lounge

ABOUT YOU (All information is confidential and will not be shared with or sold to other companies)

Name_____ Date of birth_____

Address_____

City_____ State_____ Zip_____

Home Phone #_____ Cell Phone #_____

Email Address_____ Referred By_____

Preferred appointment reminder method: ❑ Text ❑ Email

Cell Phone Provider _____

Emergency Contact Name_____ Phone #_____

YOUR HEALTH

Any current or past health conditions? (Please check all that apply)

__ High Blood Pressure
__ Menstrual Problems
__ Digestion Problems
__ Back Problems
__ Phlebitis
__ Thyroid Conditions
__ Blood Disorders
__ Heart Conditions
__ Fibromyalgia
__ PREGNANT
__ HIV/AIDS
__ Arthritis
__ Asthma
__ Polio
__ Diabetes
__ Headaches
__ Epilepsy/Seizures
__ Varicose Veins

Do you have any other medical concerns or injuries that may be pertinent to your treatment?

_____

_____

Allergies_____ Medications_____

Have you ever been treated for cancer? If yes, when and what type?

_____

_____

YOUR SKIN

Are you currently taking or have you taken any of the following in the past 6 months?

__ Accutane __ Retin A __ Renova __ Alpha Hydroxy Acid (AHA) __ Birth Control

What skin care products do you regularly use on your skin?

_____

When was the last time you used a tanning bed or were exposed to the sun?

_____

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I,_____, understand that an adverse reaction during or after my sugaring treatment may occur. If I have any concerns, I will address these with my therapist. I consent to receive sugaring treatments, massage therapy, and/or skin treatments at Sugared Beauty Lounge including, but not limited to, Massage Therapy, Facial Treatments, and Hair Removal. I hereby release Sugared Beauty Lounge, its officers, employees, agents, or its assigns from any and all liability arising from or as a result of any treatment(s) I will receive today and during all future appointments. I have given an accurate account of the questions asked above including all known allergies or prescription drugs or products I am currently ingesting or using topically. I understand my therapist will take every precaution to minimize or eliminate negative reactions as much as possible.

I have read and understand the post-treatment home care instructions. I am willing to follow recommendations made by my therapist for a home care regimen that can minimize or eliminate possible negative reactions. In the event that I may have additional questions or concerns regarding my treatment or suggested home products/post-treatment care, I will consult the therapist immediately. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered. I understand that procedure and accept the risks.

Client Name (printed)_____
Client Signature_____ Date_____
Parent/Guardian Signature (if under 18)_____

CANCELLATION POLICY

We are by appointment only. This policy is enacted out of respect for our technicians and our clients. Late cancellations can be difficult to fill. Not showing up prevents other clients from being accommodated during the scheduled time you no longer wish to use. In the event that another client may request the appointment time, we greatly appreciate notification that you would like to change or cancel your appointment so that we can better accommodate everyone. Therefore, we request that you provide at least 24 hours notice if you need to cancel or reschedule an existing appointment. We require a credit card on file in order to schedule any appointments. If you happen to no show or cancel less than 24 hours in advance we may charge the card you provided when scheduling the appointment an amount equal to 50% of the service that has been booked. If you are more than 5 minutes late to a 15 minute appointment or 10 minutes late to a 30 minute appointment, there is a high probability that we will have to reschedule your appointment or downgrade your appointment to a shorter service. By signing below, you acknowledge that you have read and understand the Cancellation Policy.

Client Name (printed)_____
Client Signature_____ Date_____
Parent/Guardian Signature (if under 18)_____