SEI TU BELLA
MODERN BOUTIQUE MED SPA
AND WELLNESS INSTITUTE

Treatment Consent Form
The SaltFacial®

I, consent to undergo The SaltFacial® treatment as described to me by my skincare professional. It has been explained to me that The SaltFacial® treatment is a safe, 3-step process comprised of Step (1): Sea Salt Resurfacing, Step (2): Aesthetic Ultrasound, and Step (3): LED Phototherapy.
It has been explained to me and I understand that although results may be seen with as little as one treatment, a series of 4 to 8 treatments may be recommended based on my skin care goals.

The SaltFacial® is considered a non-invasive treatment, meaning it does not break the skin barrier. Because of this, complications are rare, however it has been explained that I may experience some post-treatment redness, swelling, sloughing, and flaking of the treated area. I understand this is a normal response that can last for as little as a few minutes or up to several days following treatment. My skincare professional has explained the treatment expectations and I am in full understanding of this.

For more aggressive treatments, post-treatment scabbing may occur. This more aggressive type of treatment may be performed if my skincare professional has recommended it based off my desired treatment goals. Aftercare instructions for this type of treatment have been explained to me and are fully understood.

I acknowledge that I have provided my full medical history, including all medications and supplements I'm currently on.

I have informed my skincare professional of any use of Accutane within the past 12 months.

I have been instructed to discontinue use of any product containing Retin-A, retinoids, retinols, Glycolic Acid, or AHA, for 3 to 5 days PRE-treatment and 3 to 5 days POST-treatment. I acknowledge that my skincare professional has answered all of my questions, and the treatment has been explained to my satisfaction.

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It has been explained that photos will be taken before and after treatment to track my progress. I understand these photos will remain the property of this office and will not be used for any other purpose unless I agree to release them for use.

Photo Release
I agree to release my photos to my provider to use for promotional purposes, and for possible submission to the manufacturer to use for promotional purposes. It has been explained that even if the photos are chosen for use, my identity will be kept private and secure.

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I understand that the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume those risks. Prior to receiving treatment, I have been candid in revealing any condition that may have a bearing on this procedure.
I consent and authorize Sei Tu Bella Aesthetics , LLC, and it's affiliates to perform the procedure listed on me. I certify that I have read this entire informed consent and I understand and agree to the information provided in the form. My questions regarding the procedure have been answered satisfactorily. I hereby release Heather Anderson, APRN, Medical Director Dr. Fernando Jara, Sei Tu Bella Aesthetics LLC from all liabilities associated with this procedure. This consent is valid for all of my treatments in the future as well.