

- Facial
- Microdermabrasion
- Photorejuvenation
- Endermolift



Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____

Referred by: _____ Occupation: _____

List all skin products you are currently using:

Are you currently using any products containing

Retin A	No__ Yes____	Glycolic Acid	No__ Yes____
Alpha Hydroxy	No__ Yes____	Salicylic Acid	No__ Yes____

Have you had any chemical peels? Yes No

Have you ever had this treatment before? Yes No

Do you have any allergies? Yes No

Please specify: _____

Have you had any collagen, Botox® Cosmetic, or other facial injections? Yes No

Have you had any cosmetic or laser procedures? Yes No

If so, when?: _____

Are you taking any medications? Yes No

If so, which ones? _____

Are you pregnant or trying to get pregnant? Yes No

Are you nursing? Yes No

I have read and understand the above questions and have answered them to the best of my knowledge for Facial/Microdermabrasion/Photorejuvenation.

I hereby certify that the following information is true and accurate to the best of my knowledge. In case of intentionally misleading answers the physician and/or technician can not be held responsible for any adverse outcome.

I have been fully informed about the procedure and have had ample opportunity to ask questions concerning the treatment. I fully consent to treatment and agree to hold Smooth Synergy, LLC and any and all parties affiliated therewith, harmless and free from any and all liability that may arise as a result of this treatment both now and in the future.

Signature: _____ Date: _____

As a thank-you, you will receive 10% off each time you refer a friend to Smooth Synergy. You can choose to accumulate your savings and use them as you wish.

Skin Analysis

Areas to be treated: _____

Skin Type:

Normal _____ Sensitive _____

Normal to oily _____ Dry _____

Normal to dry _____ Oily _____

Please check all that apply:

Broken Capillaries _____ Sun Damage _____

Dry Patches _____ Blackheads _____

Acne Scars _____ Wrinkles _____

Acne _____ Facial scars _____

Excessive facial hair _____ Uneven skin tone _____

Enlarged pores _____ Rosacea _____

Lumps under skin _____ Freckles _____

Additional Information for Microdermabrasion

1. Have you ever had a Microdermabrasion treatment before? Yes No
2. Have you ever had a chemical peel? Yes No
3. Have you ever had a glycolic acid treatment or used a product containing glycolic acid? Yes No
If yes, when? _____
4. Have you ever used Retin-A? Yes No
If yes, when? _____
5. Do you suffer from eczema, psoriasis, or other skin disorder? Yes No
If yes, describe. _____
6. Do you suffer from inflammatory acne or pustules? Yes No
7. Do you currently have an outbreak of herpes or any symptoms? Yes No
8. Are you HIV positive? Yes No
9. Do you have diabetes? Yes No
10. Do you currently use any anticoagulant medication? Yes No
11. Do you use tanning salon treatment? Yes No
12. Are you on vacation? Yes No
13. Do you have broken capillaries? Yes No
14. Do you have a pacemaker? Yes No

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Cancellation Policy as of July 1, 2006



Client acknowledges and accepts full responsibility & guarantees full payment for all services rendered. Member agrees that Smooth Synergy may pursue all avenues of collection including use of collection agencies and authorizes Smooth Synergy to prepare and submit credit card charges using the credit card listed below to recover charges and all other unpaid amounts. If Smooth Synergy retains the services of a collection agency or attorney to effect collection, Client will promptly reimburse Smooth Synergy for all of

Smooth Synergy's reasonable and necessary attorney's fees and disbursements incurred in connection herewith.

Smooth Synergy shall also not be obligated to reimburse client for any monies that were pre-paid for treatments. It shall instead apply any unused funds towards future treatments.

Any prepaid services not used within one year of purchase shall expire and no longer be valid.

Smooth Synergy's cancellation policy is as follows:

I understand that failure to provide 24 hours notice of cancellation will result in one of the following cancellation fees:

1st time - \$25 fee

2nd time – 50% of services scheduled

3rd time – 100% of services scheduled

The fee for canceling an appointment with Dr. Liakeas is \$50 for the first cancellation, 50% of the treatment price for the second, and 100% of the treatment price for the third cancellation.

Whichever fee I incur will automatically be charged to my credit card.

Credit Card Name & Number: _____

Exp. Date _____ Billing Zip Code: _____

Patient name (print): _____

Signature: _____ Date: _____

****Please note: WE DO NOT ACCEPT CHECKS.**

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