JFSKINCARE
JENNIFER FLORES, AESTHETICIAN

# CONSULTATION & PHOTO CONSENT

(PLEASE COMPLETE ALL SHADED AREAS OF THIS FORM)

Name: _____ Age:_____ Date: ____/____, 2023

Allergies: _____ _____ _____

Chief Issue: _____

Medical History: _____

Surgical History: _____

Medications: _____Current Products:_____

**Assessment**

Patient: _____

Recommendations: _____

Plan: _____

Financial Quote: ____ $ _____

I understand my consultation with Jennifer Flores, Esthetician and will follow with pre and post treatment instructions. I also agree to the consent of photographs pertaining to my treatment. I certify that I have read and understood fully without question the contents of this Consultation & Photo consent form.

Patient: _____ Date:____/____, 2023

I certify that I have discussed **ALL** of the above with the patient and have offered to answer any question regarding the pre and post treatment instructions, and I believe that the patient fully understands the explanations and answers.

Clinician: _____ Date: ____/____, 2023

Start of Treatment Photo

6 Months Photo

Form# 04-2023