

hair free Direct Debit Authorization

Direct Debit Authorization

In accordance with the Customer Agreement from _____, I revocably authorise the hair free institute (proprietor: _____) to collect amounts due (treatment price, down payment, instalments) by means of direct debit from the following account:

Bank: _____
 BIC: _____
 Account No.: _____
 IBAN: _____
 BIC: _____

Place, date: _____ Customer: _____

hair free Direct Debit Authorization (1/12) (Valid from 10.03.2012)

Lastschriftinzug englisch

hair free Questionnaire 1

Dear hairfree customer,

We ask you to fill out this questionnaire so that we can optimally advise you. We will handle your data confidentially, and naturally we are bound to professional discretion.

Many thanks for your understanding
Your hairfree institute

How did you first get out about us?
 Last name, first name, date of birth: _____
 Street, postal code, place: _____
 Tel. and e-mail address: _____

Where do you depilate your body? (multiple selection possible!)
 Arms pits Abdomen Arms Face Genital area Breast
 Thighs Lower leg Back Buttocks Bikini zone Not at all

How do you depilate your body? (multiple selection possible!)
 Electric shaving Depilatory cream Epilation devices
 Electrolysis Wax shaving Plucking Not at all

How much time do you spend weekly for your body depilation?
 1-5 min. 6-10 min. 10-20 min. Over 20 min.

How much money do you spend monthly for depilation?
 0€ up to 10€ up to 20€ up to 30€ Over 30€

Do you know our treatment method, and have you already had experience with permanent hair removal?
 No Yes

How important are the following aspects to you

	1	2	3	4	5	6
More time for the nice and important things in life						
Saving money						
Better appearance						
Sportsmen for hobbies, family and friends						
Medicinal body, well-being, personal well-being						
Self-assurance, self-confidence						

Ort, Datum: _____ Unterschrift: _____

hair free Questionnaire 1 (1/12) (Valid from 10.03.2012)

Fragebogen 1 englisch
DE und CH

hair free Questionnaire 2

Dear hairfree customer,

In order to ensure a safe treatment, we ask you to carefully fill out this questionnaire. In this way we can prepare ourselves for possible contraindications. We will handle your data confidentially, and naturally we are bound to professional discretion.

Many thanks for your understanding
Your hairfree institute

Last name, first name, date of birth: _____

	Yes	No
Are you currently taking medications? If yes, please indicate these:	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently taking St. John's wort or other photosensitising preparations?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with cancer in the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware of cardiovascular diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been diagnosed with vein problems?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have an infection?	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
Are you in a hormonal transition (e.g. menopause)?	<input type="checkbox"/>	<input type="checkbox"/>
Are you currently pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a pacemaker?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have allergies? If yes, specify:	<input type="checkbox"/>	<input type="checkbox"/>
Do you regularly take sunbaths (natural, artificial)?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been vaccinated in the last 14 days or is a vaccination planned?	<input type="checkbox"/>	<input type="checkbox"/>

Place, date: _____ Signature: _____

hair free Questionnaire 2 (1/12) (Valid from 10.03.2012)

Fragebogen 2 englisch



Hände-Desinfektion



Thermalwasser-Spray, 50 ml



Einmal-Mundschutz



Raumduftspray und Aromat



Ultraschall Gel