Consent Form

☐ Laser Resurfacing ☐ Chemical Pee ☐ Dermaplaning ☐ Micro Dermabrasion

Our peels contain a synergistic blend of powerful ingredients suitable for all skin types. It will improve the tone, texture and clarity of the skin; reduce age spots, improve hyperpigmentation (including melasma), soften lines and wrinkles; clear acneic skin conditions; reduce or eliminate acne scars; and stimulate the production of collagen, for firmer, more youthful skin.

Contraindications:

- Patients who are pregnant or who are breast feeding
- Patients who have an aspirin allergy or phenol allergy
- Patients who have used Accutane within the past 3 months
- Patients who on any medications that causes photosensitivity
- Patients who have active cold sores, warts, open wounds or history of herpes simplex
- Patients who are undergoing chemotherapy and or radiation therapy
- Patients with a history of an autoimmune disease or any condition that may weaken their immune system

Please read and initial the following:

_____Prior to receiving treatment I have communicated with the Physician/Clinician about any conditions or medications that may contraindicate this procedure.

_____ I understand that there may be some degree of discomfort such as burning, stinging, redness, heat or tightness during and a week after the procedure.

_____ I understand that there is no guarantee of the final results. Occasionally hyperpigmentation may develop which may persist for week or months after the peel.

_____ I understand although complications are very rare, sometimes they may occur. In the event of any complications, I will immediately contact the Physician/Clinician who performed the treatment.

_____I understand that maintenance treatments are necessary to maintain results as well as the recommended skin care regimen & SPF 30.

_____I understand that I must protect my skin and avoid sun exposure during the exfoliation process.

_____I understand that this is an elective cosmetic procedure and is non-refundable. I understand payment is my sole responsibility.

____ I understand that no other chemical peels or medical device treatments may be performed on my skin until my Physician/Clinician releases me to do so.

_____ _____

Patient signature date

_____ _____

Clinician signature date

PEEL TYPE: _____ LOT # _____ EXP DATE: _____