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Facial, Chemical Peel and Microdermabrasion Consent Form

Patient Name _____

Date _____

Prior to receiving treatment, I have been candid in revealing any condition that may have bearing on the procedure, such as; pregnancy (if so, so do not perform the treatment), recent facial surgery, allergies, tendency for cold sores/fever blisters, use of Retin-A, Accutane, or hormones.

I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied. I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complications I will immediately contact the physician/aesthetician who performed the treatment and I will also seek medical care. _____ **(Please Initial)**

I understand there may be some discomfort such as stinging, pinpricking sensation, hotness or tightness. I may experience mild sunburn or wind burn sensation as well as a mild acne outbreak. I understand that underlying moles, blood vessels, sun spots may become more obvious or darker after treatment since layers of damaged skin have been removed. _____ **(Please Initial)**

I understand that there are no guarantees as to the results of this treatment, due to many variables, such as age, condition of the skin, sun damage, smoking, climate, sensitivity of the skin, and hormones. I understand I may or may not peel. _____ **(Please Initial)**

I understand that to achieve maximum results several treatments may be needed. _____ **(Please Initial)**

I agree to refrain from tanning while I am undergoing treatments and during the 14 days following each treatment. SPF 30 or higher is mandatory and direct sun exposure is prohibited. _____ **(Please Initial)**

I understand that I need to give 24 hour notice if I am not able to keep my appointment. If I do NOT give 24 hour notice I will forfeit one of my treatments in the package. _____ **(Please Initial)**

I hereby agree to all of the above and agree to have this treatment performed on me. I further agree to follow all post-treatment care instructions as I am directed.

Patient Signature _____ Date _____

Provider Signature _____ Date _____