CONSENT FOR FACIAL PEEL TREATMENT

Schenden's medical day spa

Client Name: _____ *Skin Assessment Completed*? ☐ Yes *Date* ☐ No

Facial Peels (hereinafter "clinical procedures") are not a "cure all" treatment. However, for certain skin conditions, these clinical procedures can provide marked improvement in the appearance of one's skin. Therefore, it is very important that you have a thorough understanding of what these clinical procedures can and cannot do for your particular skin conditions. In addition, it is imperative that you acknowledge the potential risks associated with clinical procedures.

Please initial the box below, to indicate which clinical procedure(s) you are consenting to:

☐ Dermaplaning	*Date* _____	☐ Microdermabrasion	*Date* _____	☐ Glycolic	*Date* _____
☐ Lactic	*Date* _____	☐ Salicylic	*Date* _____	☐ Probiotic	*Date* _____
☐ Jessner	*Date* _____	☐ Mybody	*Date* _____	☐ TCA	*Date* _____

Before subjecting yourself to any clinical procedures, read carefully the following statements. After you have read each statement, please initial each respective in the space that has been provided.

- The clinical procedure has been explained in detail by the physician and/or members of the physician's staff. *Initial* _____
- I understand that the clinical procedure is a skin rejuvenation treatment and that I may need several administrations of clinical procedures in order to achieve the best results. *Initial* _____
- I understand that for optimum results, a home treatment program is needed to enhance the results of clinical procedure. *Initial* _____

Discomfort	This is usually minimal and of short duration.
Swelling	This is very unusual, but if it occurs will be minimal and usually subsides in a few hours to a few days.
Reddening	A red discoloration may persist anywhere from a few days to several weeks.
Demarcation	Refers to the difference in color, texture, or pigmentation that may occur at the junction between the treated and non-treated skin areas.
Existing Blemishes	Moles, blood vessels (telangiectasias), freckles and sunspots may become more obvious and darker since layers of dead skin have been removed.
Eye Injury	If chemicals get into the eye, scarring and vision disturbances may occur. Protective safety glasses should be worn while chemicals are being used during the clinical procedure.
Scarring	Is very unusual, but may occur.
Pigmentation	Although extremely rare, temporary and possibly permanent changes in the color of the skin may occur.
Milia	May occur, but will usually disappear quickly.
Infection	Is extremely unlikely, but may occur. An outbreak of herpes may occur in effected individuals (ask your physician about an antiviral medication if you are prone to cold sores).
Hair Growth	If the dermaplaning phase is administered, hair is expected to grow back blunt-ended. New hair will not appear darker or denser. Any hormonal imbalance that may be present within your anatomical system can alter the normal hair growth pattern and cause a darker and denser restoration process.
General	Any and all risks and complications can result in additional surgery, hospitalization, time off work and expenses to you.
Note	Should one or more of the foregoing complications arise, please notify the office immediately. Early detection and treatment may minimize complications. The foregoing list is not intended to be a complete or exhaustive list of all possible complications, which may arise as a result of clinical procedures.

Accutane Release

_____ I acknowledge that I have **NOT** taken the oral pharmaceutical medication Accutane (or equivalent) within the *last twelve months.* I understand the potential risks involved with Accutane therapy and the problems that could occur when employed in conjunction with clinical treatments.

Please Initial

_____ I agree to follow post procedure guidelines recommended and notify therapist with any concerns.

_____ I understand that clinical procedures need not be administered by a physician. It is also my understanding that, in addition to receiving formal training, any non-physician medical assistant (ie: RN, LPN, surgical technician, cosmetologist or aesthetician) who administers clinical procedures has had her/his skills reviewed and endorsed by the supervising or attending physician.

_____ I understand that if I experience any adverse side effects that appear to be attributed to my use of homecare products, I would discontinue use of the products immediately and notify the office.

_____ 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 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 this is an elective cosmetic procedure and is non‐refundable. I understand payment is my sole responsibility.

_____ I understand that aesthetic services offered are not a substitute for medical care, and any information provided by the therapist(s) is confidential and for educational purposes only. I do not need a doctor's release for any services provided.

_____ I understand that it is extremely important to strictly follow all homecare instructions for optimal results.

_____ I have filled out the history sheet correctly and accurately. I understand failure to inform the therapist of any conditions could affect treatment result.

- I hereby give my consent to receive spa treatments and release this business as well as the therapist(s) from any current or future claims with treatment(s).
- I am aware, depending on the treatment(s), I may experience some temporary mild discomfort such as soreness, bruising, stinging, warm flushing or redness as well as other possible effects explained to me. Those prone to cold sores may have a breakout after treatment. Valtrex is recommended.

_____ _____

*Client Signature*** *Date* *Technician Signature* *Date*

*****If client is under 18- Signature of Responsible Adult Required*

Technician Acknowledgement: I certify that I have discussed ALL of the above with the patient and have offered to answer any questions regarding the in-office procedures, and I believe that the patient fully understands the explanations and answers.

_____

Technician Signature *Date*