INFORMED CONSENT FOR DERMAPLANING

I,_____, give permission to my skin care professional at R & R Medical Wellness to perform a dermaplaning treatment.

1. I agree to complete a Confidential Skin Health Questionnaire (Client Profile and Questionnaire). I agree to complete and be truthful about my physical conditions, pregnancy, medications that I may be taking, and my current skin care regimen. I am also aware that my lifestyle, which if it includes smoking, outdoor exposure, tanning beds, excessive alcohol consumption and/or recreational use of controlled substances, will effect and diminish the effectiveness and result of the treatment. My expectations are realistic and I understand that the results are not guaranteed and that for maximum results, more than one application may be necessary. The rate of improvement depends on my skin type, condition, my age, degree of sun damage, or pigmentation levels.

2. I have disclosed to my skin care professional any surgical procedures, laser treatments, or facial procedures that I have had or intend on having in the future.

3. I am not presently pregnant or lactating.

4. I have not had any recent chemotherapy or radiation treatments.

5. I have not recently waxed or used a depilatory (such as Nair) on the area being treated today. I do not have a history of keloid scarring, diabetes, any autoimmune disease, active herpes blisters or cold sores.

6. I have not had any other exfoliating or peel treatment of any kind within 14 days of treatment. I understand I cannot have another treatment within 14 days of this treatment, whether the treatment is performed at this location or any other location.

7. I understand that sun exposure is prohibited while I am undergoing treatment and that the use of Circadia Light Day Broad Spectrum Sunscreen SPF 37 is mandatory. I agree to refrain from excessive sun exposure or the use of a tanning bed while I am undergoing treatment and during the 14 days following the end of treatment.

8. I understand the purpose of this procedure is to exfoliate the outer surface of my skin. Some of the benefits include lessening of pigmentation, reduction in appearance of fine lines and wrinkles, and the removal of some if not all vellus hair.

9. I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complication, I will immediately contact the skin care professional who performed the treatment.

10. I understand the cost of treatment and the fee structure has been explained to me.

11. I understand that my practitioner will recommend home care products to work in tandem with the in-clinic treatment. I am willing to follow recommendations by my skin care professional for home care, including a sunscreen.

12. I understand the possibility of peeling, flaking, hyper-pigmentation and excessive dryness. I agree to use the products specifically recommended by my skin care professional/esthetician.

13. I understand that every precaution will be taken to minimize or eliminate negative reactions such as blisters, redness, scratches, or irritation. I understand that erythema may be worsened or brought out by exfoliation.

14. I consent to the taking of photographs to monitor treatment effect and results if desired by my skin care professional and to the publication of these photographs on social media and/or professional websites.

15. I realize and understand the goal of this treatment is for the removal of cellular debris, minimal facial skin exfoliation, and skin rejuvenation. I understand that this treatment uses a disposable medical blade, which is mildly abrasive, and will follow explicit instructions given by my skin care professional/esthetician.

16. I understand aerobic exercise or vigorous physical activity should be avoided until all redness has subsided.

17. I understand that the following conditions preclude me from having this treatment at this time and verify that none of these conditions apply to me at this time. Certain conditions are recognized as contraindications for Dermaplaning and must be disclosed prior to treatment.

    - Vascular lesions
    - Thick, dark facial hair
    - Uncontrolled diabetes
    - Sunburned or wind-burned skin
    - Recent peels within eight weeks
    - Allergic to citrus or any citrus sensitivity
    - Allergic to aspirin or any salicylic sensitivity
    - Use of Accutane® within the past 12 months
    - History of hypertrophic scarring or keloid formation
    - Hemophilia or taking oral blood thinner medications
    - Hormonal therapy that produces thick pigmentation
    - Eczema, dermatitis, rosacea, scleroderma, skin cancer
    - Currently undergoing chemotherapy or radiation treatments
    - Use of glycolic acid or alpha-hydroxy acids within the past 4 weeks
    - Use of Retin-A®, Renova®, retinoids (Vitamin A) within the past 6 weeks
    - Broken skin, active acne, raised lesions, or moles on areas to be treated
    - Active infection of any type, such as herpes simplex virus (cold sores) or warts

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In the event of any questions or concerns, I will consult my skin care professional immediately. I understand the potential risks and complications and I have chosen to proceed with the treatment after careful consideration of both known and unknown risks, complications, and limitations. I will hold the skin care professional and staff harmless from any liability that may result from this treatment.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

Client Signature _____ Date _____

Skin Care Professional _____ Date _____