PATIENT CONSENT

AlumierMD

FULL DISCLOSURE

Prior to receiving treatment, I have reviewed and signed the Patient Profile given to me by my physician/skincare professional. I have been truthful in disclosing information that may have bearing on this procedure including the following:

- **Accutane use**
- **Nursing/lactating**
- **Allergies**
- **Autoimmune illness**
- **Pregnancy**
- **History of cold sores**
- **Aspirin allergy**
- **Cancer treatment**

POSSIBLE ADVERSE EVENTS

I have been informed that the following may occur post treatment:

- **Hyperpigmentation/hypopigmentation: I agree to follow the recommended post-procedure instructions to minimize the chance of this occurring.**
- **Allergic reaction: I also understand that exposure to different ingredients found in the treatment and associated home care products may result in an allergic reaction.**
- **Contact dermatitis, inflammation (redness), edema (swelling), skin irritation (itchiness)**
- **Temporary sensation of heat and itchiness immediately following treatment**
- **Scarring (rare)**

If any of the above occurs, I will immediately discontinue use of all professional treatments and AlumierMD home care products and consult my physician.

PEELING

I understand that the treated area may or may not actually peel and that each treatment is individual. I understand that the degree of peeling does not necessarily reflect the efficacy of the procedure.

CONDITIONS OF TREATMENT

I agree to refrain from the following activities for 14 days post treatment: Sun or tanning bed exposure • Microdermabrasion • Laser hair removal • Photofacials • Chemical peels • Laser or RF skin treatments

I agree to refrain from the following activities for 7 days post treatment:

- **Waxing, threading, and use of all other depilatories**
- **Neurotoxin injections (eg. Botox, Dysport)**
- **Dermal filler injections**
- **Use of retinoids • Use of mechanical exfoliants**
- **Use of topical AHA/BHA and all other exfoliant topical skincare products**
- **Use of sunless tanning products**
- **Acne topical treatments**
- **I have disclosed all prescription and non-prescription products that I am using.**
- **I agree to follow all post-procedure protocols recommended by my physician/skincare professional.**
- **I agree to use the recommended sun protection product (SPF 30 or higher) on the treated area for a minimum of 14 days post treatment.**

LIMITATIONS TO TREATMENT

I understand there are no guarantees as to the results of this treatment due to many variables including age, skin condition, sun damage, smoking, climate, etc. I understand that this treatment is cosmetic and that no medical claims are expressed or implied by AlumierMD or by the skincare professional. I understand that to achieve maximum results, I may require several treatments.

ADVERSE EVENTS

I understand that although adverse events are rare, they do occur and prompt treatment is necessary. In the event of any adverse event, I will contact the physician/skincare professional who performed my treatment.

I hereby certify that all the information that I have provided has been accurate and truthful. I acknowledge reading all the information contained herein regarding the possible adverse events associated with the treatment. I will receive and acknowledge the limitations and adverse events of such treatment. I further acknowledge that these limitations and adverse events have been explained and that I accept and consent to treatment. I agree to follow all post-treatment care instructions provided to me. I acknowledge that I have been provided with adequate time to read, understand and accept the above limitations and complications.

TREATMENT LOG							
	DATE						
	INITIAL						
	TREATMENT						

Patient signature: ______________________ Date: ______________________