

CONSENT FORM FOR FACIAL TREATMENTS

Phi Clinic LLC

[Your Clinic Address]

[Your Contact Information]

Patient Information

Full Name: _____

Date of Birth: _____ Phone: _____

Email: _____

Treatment Information

I, [Patient Name], consent to receive a non-invasive facial treatment, which may include but is not limited to:

- Deep Cleansing Facial
- Hydrating Facial
- Chemical Peel
- Microdermabrasion
- LED Light Therapy
- Dermaplaning
- Microneedling (excluding PRP)
- Other: _____

Acknowledgment & Risks

I understand that:

- The treatment is not a medical procedure and does not replace professional dermatological care.
- I may experience temporary redness, mild irritation, or sensitivity after the procedure.
- I must disclose any allergies, skin conditions, or recent treatments before proceeding.
- Results vary by individual and multiple sessions may be needed for optimal results.
- Certain treatments may increase skin sensitivity to the sun, requiring sunscreen application.

Contraindications

I confirm that I do NOT have any of the following conditions:

- Active skin infections (e.g., cold sores, bacterial or fungal infections)
- Open wounds, burns, or severe acne
- Recent facial surgery or laser treatments (within 2 weeks)
- Allergy to any ingredients used in the treatment
- Pregnancy or breastfeeding (for certain chemical peels or treatments)

Pre-Treatment & Aftercare Instructions

- Avoid harsh exfoliants, retinoids, and direct sun exposure 48 hours before and after treatment.
- Keep skin hydrated and use a broad-spectrum SPF 30+ sunscreen.
- Avoid touching, rubbing, or applying heavy makeup immediately post-treatment.

Consent & Release

I have read and understand the information above. I acknowledge that I have had the opportunity to ask questions and that the treatment has been explained to me. I assume all risks associated with the procedure and release Phi Clinic LLC and its staff from any liability.

Patient Signature: _____ Date: _____

Clinician Name: _____ Signature: _____