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## **PATIENT CONSENT FOR SUPERFICIAL PEEL**

I \_\_\_\_\_ give my consent to receive treatment/s from a licensed professional at Smooth Epilator. I understand the risks and potential side effects of this treatment may include:

1. Erythema (Redness)
2. Irritation
3. Swelling
4. Temporary Discoloration
5. Dryness
6. Flaking/Skin Peeling
7. Skin Tightness

I have been informed about this specific peel treatment and its possible side effects. I have released all medication and health information to the providing licensed professional. No guarantees have been made in regards to final results or lessened potential risks.

Furthermore, I consent to the administration of this peel and any possible future chemical peels by the authorized professional(s) of this spa and/or medical facility, and abide to carefully adhere to/follow all post-operative instructions given.

\_\_\_\_\_  
Signature of Client/Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Licensed Professional

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date