

PATIENT CONSENT

FULL DISCLOSURE

Prior to receiving treatment, I have completed 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, without limitation:

- I have not taken Roaccutane in the last six months
- I am not pregnant/IVF/breastfeeding
- I have declared all known allergies including Aspirin.
- I do not have an autoimmune illness
- I have not had a cold sore in the last 7 days
- I am not currently receiving cancer treatment
- I have disclosed all prescription and non-prescription products that I am using

CONDITIONS OF TREATMENT

- 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. I understand AlumierMD recommends using a sunscreen of SPF 40 or higher.
- I agree to refrain from the following activities for **7 days** post treatment and accept full responsibility for any adverse event that occurs as a result of my participation in these activities:
 - Waxing, threading, and use of all other depilatories
 - Neurotoxin injections (e.g., Botox, Dysport)
 - 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 agree to refrain from the following activities for 14 days post treatment and accept full responsibility for any adverse event that occurs as a result of my participation in these activities:

- Sun or tanning bed exposure
- Microdermabrasion
- Laser hair removal
- Dermal filler injections

- I understand and accept that the following may occur post treatment:

- **Likely:** Temporary sensation of heat and itchiness immediately following treatment
- **Possible:** Contact dermatitis, inflammation (redness), oedema (swelling), skin irritation (itchiness)
- **Unlikely:** Hyperpigmentation/ hypopigmentation: I agree to follow the recommended post-procedure instructions to minimise the chance of this occurring.

LIMITATIONS OF CHEMICAL PEELING 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 habits and climate.
- 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.
- I understand that there are ultimately no guarantees as to the results of this treatment.

PATIENT CONSENT

POSSIBLE 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 outlined below I will immediately discontinue use of all professional treatments and contact the physician/skincare professional who performed my treatment.

CONSENT TO 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, that such adverse events have been properly explained and that I consent to such treatment with full knowledge thereof.
- I acknowledge that I have been able to ask any questions regarding my concerns around this treatment.
- I hereby agree to treatment in alignment with all considerations outlined in this consent form.

	TX1	TX2	TX3	TX4	TX5	TX6	TX7	TX8	TX9	TX10	TX11	TX12	TX13	TX14	TX15	TX16
DATE																
INITIAL																

SIGNED PATIENT _____

DATED _____

SIGNED PRACTITIONER _____

DATED _____