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## Mandala Med-Spa and Yoga Shala L.L.C.

## Dermaplaning Consent

**Please read this consent form thoroughly and initial each section. Discuss any questions or concerns with your  
skin care professional before you initial the form. Your signature and date at the bottom constitutes your consent  
to have a dermaplaning/peel treatment.**

1) I have completed the client questionnaire accurately. \_\_\_\_\_\_

2) I have been candid in revealing any condition that could prohibit this treatment such as cold sores, pregnancy, use of hormones, recent facial surgery or IPL/Laser treatments, use of Retin-A/ Renova/ Tretinoin or Accutane within the past year. I do not have any immune system diseases including but not limited to Lupus, HIV or Cancer treatments. \_\_\_\_\_\_

3) I understand **there are no guaranteed results** from this treatment. Many variables affect the outcome of this treatment. Variables include but are not limited to age, sun damage, on-going sun exposure, skin thickness and sensitivity, vascularity, smoking, excessive alcohol intake, diet and water consumption, medications and overall health status.It is important to discuss all of these with your skin care professional. **I understand that each case is individual.** \_\_\_\_\_\_

4) Regardless of the precautions taken, I acknowledge the possibility of an adverse reaction to the peel and accept sole responsibility for any medical care that may become necessary. I will **immediately contact** the skin care professional performing the treatment of any adverse reactions. \_\_\_\_\_\_

5) **I will not scratch, pick, pull at or abrade the treated skin.** \_\_\_\_\_\_

6) I understand that **direct sun exposure and use of tanning booths is** **prohibited** during this treatment time and that it is **mandatory that I use a minimum SPF 28 sun protection daily.** \_\_\_\_\_\_

7) I have not received any other peels, exfoliation or hair removal of any kind within 14 days of this treatment nor will I have any during the next 14 days. \_\_\_\_\_\_

8) I understand that **I must adhere to the recommended home care routine to achieve maximum results and to avoid the increased risk of adverse reactions.** If I change the routine or use products not recommended by the skin care professional my results could be altered or inhibited. I also understand that **it may take several treatments to obtain the desired results.** \_\_\_\_\_\_

9) I understand the following **side effects** **or complications** can occur:

1. Discomfort *- minimal if any and of short duration*
2. Redness *- may persist for a few hours to days*
3. Pigmentation - *rare, temporary but could be permanent*
4. Nicks/Abrasions - *use of scalpel blade may result in minor cuts*
5. Blemishes - *acne, spots, moles and broken capillaries may be more obvious*
6. Itching or irritation *- mild if any and of short duration*
7. Infection - *very unlikely but may occur*
8. Scarring - *very unlikely but may occur*
9. Hair Growth - *hair is expected to grow back blunt-ended but will not appear coarser or darker*

10) The skin care professional has explained the benefits, limitations and possible adverse effects of the treatment to me and I clearly understand this information. \_\_\_\_\_\_

11) I consent to photographs being taken to evaluate treatment effectiveness as well as for medical education and training.  
No photographs revealing my identity will be used without my written consent. \_\_\_\_\_\_

12) The skin care professional has provided the above information as well as written care instructions. My questions have been answered and I freely consent to the proposed treatment. \_\_\_\_\_

**Print Name**  **Signature**  **Date**\_\_\_\_ \_\_\_\_

**Witness Name**  **Signature**  **Date**\_\_\_\_ \_\_\_\_

**Skin Care Professional**  **Phone**  **Date**\_\_\_\_\_\_\_\_\_