INFORMED CONSENT FOR DERMAPLANING

I, _____, give permission to my skin care professional, to perform a dermaplaning treatment.

I agree to complete a Confidential Skin Health Questionnaire. I agree to complete and be truthful about my physical conditions, pregnancy, medications that I may be taking, and my current skin care regimen. I am also aware that my lifestyle, which if it includes smoking, outdoor exposure, tanning beds, excessive alcohol consumption, and/or recreational use of controlled substances, will affect and diminish the effectiveness and result of the treatment.

1. I have disclosed to my skin care professional any surgical procedures, laser treatments, or facial procedures that I have had or intend to have in the future.

2. I have not received Botox or fillers within 2 weeks of this appointment.

3. I have not used any form of Vitamin A (retinol) within the past 5 days and will not use Vitamin A for 5 days after the service.

4. I have not had any recent chemotherapy or radiation treatments in the past year.

5. I have not recently waxed or used a depilatory (such as Nair) on the area being treated today. I do not have a history of keloid scarring, diabetes, any autoimmune disease, active herpes blisters, or cold sores.

6. I have not had any other peel treatment of any kind within 14 days of treatment. I understand I cannot have another treatment within 14 days of this treatment, whether the treatment is performed at this location or any other location.

7. I agree to refrain from excessive sun exposure or the use of a tanning bed while I am undergoing treatment and during the 14 days following the end of the treatment.

8. I understand that sun exposure is prohibited while I am undergoing treatment and that the use of a Broad Spectrum Sunscreen SPF 30 is mandatory.

9. I understand the purpose of this procedure is to exfoliate the outer surface of my skin. Some of the benefits include lessening of pigmentation, reduction in the appearance of fine lines and wrinkles, and control of certain conditions such as acne or occasional breakouts.

10. I understand that the following conditions preclude me from having this treatment currently and verify that none of these conditions apply to me at this time.

_____ Broken skin on areas to be treated
_____ Sunburn or windburn skin
_____ Visible inflammatory or inflammatory lesions
_____ Herpes virus (cold sores) on mouth
_____ Laser Hair Removal within 6 weeks
_____ Use of glycolic acid products
_____ Use of Retin-A®, Renova®, retinoids (Vitamin A) in the last 4 weeks
_____ Allergic to citric fruits (oranges, limes, grapefruit, lemons)
_____ Allergic to cocoa, chocolate, and/or raspberry
_____ Allergic to pineapple and/or papaya
_____ Allergic to aspirin or have any sensitivity to salicylic acid (Alpha-Beta Peel)

11. My expectations are realistic, and I understand that the results are not guaranteed and that for maximum results, more than one application may be necessary. The rate of improvement depends on my skin type, condition, age, degree of sun damage, or pigmentation levels.

12. I understand that although complications are very rare, sometimes they may occur, and that prompt treatment is necessary. In the event of any complication, I will immediately contact the facility where treatment was performed.

13. I understand the possibility of peeling, flaking, hyperpigmentation, and excessive dryness. I agree to use the products specifically recommended by my skincare professional.

14. I understand that every precaution will be taken to minimize or eliminate negative reactions such as blisters, redness, or irritation.

15. I consent to the taking of photographs to monitor treatment effects and results if desired by my skincare professional.

In the event of any questions or concerns, I will consult my skin care professional immediately. I understand the potential risks and complications and I have chosen to proceed with the treatment after careful consideration of both known and unknown risks, complications, and limitations. I will hold the skin care professional and staff harmless from any liability that may result from this treatment.

I agree that this constitutes full disclosure and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

Client Signature _____ Date _____

Skincare Professional _____ Date _____