PATIENT INFORMED CONSENT

Patient Name: _____ Date: _____

Before your treatment today, we want to make certain that you are fully aware of the procedure(s) you are having and any potential risks involved. The Transition Peel and/or Dermal Edge Peel cannot be considered "cure all" treatments. For certain conditions, however, these peels can provide marked improvement in the appearance of the skin. Therefore, it is essential that you have a thorough understanding of what these peels can and can not do for your particular skin type and skin condition. In addition, it is imperative that you acknowledge the potential risks associated with these peels.

Prior to authorizing us to perform your procedure(s), it is essential that you agree with each of the following statements:
(please initial each item)

1. _____ The proposed treatment was explained to me in detail and in a way I understand. I am fully aware that this is a program of treatment which may require several treatments in order to achieve the best possible results.

2. _____ I have fully informed the Skin Care Specialist of my comprehensive medical history, current medications, current skin care regimen and any other conditions, such as cold sores, pregnancy, use of hormones, recent facial surgery or laser resurfacing, recent use of Retin-A or use of Accutane within the past 12 months that would contraindicate my scheduled treatment(s). I further realize that my failure to do so could result in significant complications.

3. _____ I understand that the degree of improvement I can expect to see is dependent upon many variables and that strict adherence to the post treatment/home care instructions is essential to ensuring my best results. I also understand there are no guaranteed results from this treatment(s) due to many variables, which can affect the final result: excessive sun damage, ongoing sun exposure, smoking, excessive alcohol intake, climate, diet, water intake, skin thickness and sensitivity. I also understand that I may or may not peel, and that each case is individual.

4. _____ Regardless of 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. In the event I do experience an adverse reaction, I will promptly contact the office that performed my treatment so that I may be seen immediately.

5. _____ I understand that direct sun exposure and use of a tanning booth is prohibited during the treatment and healing time, and that daily use of sun protection, with a minimum of SPF 15, is absolutely necessary.

6. _____ I agree that I will not scratch, pick, pull at, or abrade the treated skin and acknowledge that if I fail to comply with these instructions or any other post treatment/home care instructions, I will be solely responsible for any negative outcome of having this procedure.

7. _____ I understand that to achieve the maximum results the recommended post treatment/home care instructions must be followed. I understand that if I alter the routine or use products not recommended by my Skin Care Professional, my results could be altered. I also understand that it may take several treatments to obtain the desired results.

8. _____ I understand that the following side effects or complications can occur: discomfort, swelling, redness, hypo- or hyperpigmentation, itching or irritation, scrapes, skin peeling or flaking up to 14 days after the procedure, infection, scaring and acne breakouts.

9. _____ I consent to having a representative of the Clinic take photographs to be included as part of my medical/skin care record.

I understand the goals of the treatment as well as the limitations and therefore, I give my consent for my Skin Care Specialist, under

the direction of _____ to perform the scheduled treatment on my face and/or other area(s) of my body.

Patient Signature: _____ Date: _____

Skin Care Specialist: _____ Date: _____