



## INFORMED CONSENT FOR IMAGE TREATMENTS

### PATIENT/CLIENT INFORMATION

DATE _____	HOME PHONE _____
NAME _____	WORK PHONE _____
ADDRESS _____	CELL _____
CITY _____	EMAIL _____
STATE/ZIP _____	FAX _____

### TREATMENT (Please initial by each statement)

\_\_\_\_\_ The treatment was explained to me in detail.

\_\_\_\_\_ The benefits of what I can realistically expect to see from my Clinical Peel have been fully explained to me.

### TREATMENT (Please select one)

- |  |   |
|--|---|
| <input type="radio"/> I PEEL ormedic lift™           | <input type="radio"/> I PEEL acne lift®             |
| <input type="radio"/> I PEEL the signature facelift® | <input type="radio"/> I PEEL advanced BHA lift      |
| <input type="radio"/> I PEEL lightening lift®        | <input type="radio"/> I PEEL perfection lift™       |
| <input type="radio"/> I PEEL lightening lift®FORTE   | <input type="radio"/> I PEEL perfection lift™ FORTE |
| <input type="radio"/> I PEEL wrinkle lift®           | <input type="radio"/> O <sup>2</sup> lift®          |
| <input type="radio"/> I PEEL wrinkle lift®FORTE      | <input type="radio"/> IMAGE facial                  |

### SKIN CONDITION (Please select all that apply)

- |   |                   |
|---|-------------------|
| _____ SUPERFICIAL WRINKLES, FINE LINES            | _____ ROSACEA     |
| _____ DEEP WRINKLES, FINE LINES                   | _____ DEHYDRATION |
| _____ ACNE OR ACNE PRONE                          | _____ ACNE SCARS  |
| _____ DEEP HYPERPIGMENTATION (SUN OR BROWN SPOTS) | _____ UNBALANCED  |
| _____ SEVERE PHOTOAGING                           |                   |

### PRECAUTIONS (Please read carefully)

**The treatment** you will receive is a clinical treatment designed to exfoliate or remove the outer layers of the skin.

**Your participation** in your skincare treatments will determine the outcome. It is important that you strictly adhere to your home care products that your aesthetician has recommended.

**No guarantee** is expressed or implied as to the precise results, peeling times or discomfort.

**During the treatment**, you may experience some temporary stinging or warm flushing. This will fade within a few minutes. During the next few hours, you may experience some tightening of the skin, which may last for several days.

**For most patients**, flaking begins within 48 hours. It is impossible to pre-determine how much peeling will occur. The shedding process usually subsides within 5-7 days.

**Depending on the clinical peel** performed and your skin quality, the following reactions may occur in some patients:

1) Prolonged redness, irritation and flakiness 2) Dryness and sensitivity 3) Severe allergic reactions in rare instances

### PLEASE INITIAL (Please read carefully)

- |  |  |
|--|--|
| _____ I AM NOT PREGNANT.   | _____ I DO NOT HAVE ACTIVE COLD SORES.   |
| _____ I AM NOT ALLERGIC TO ASPIRIN.  | _____ I HAVE NOT RECEIVED RADIATION TREATMENTS.  |
| _____ I HAVE NOT USED GLYCOLIC ACID FOR 24 HRS.                                    | _____ I AGREE IT IS MANDATORY TO USE IMAGE POST PEEL KIT.  |
| _____ I HAVE NOT USED RETINOL PRODUCTS FOR 72 HRS.                                 | _____ I AGREE TO AVOID DIRECT SUN EXPOSURE FOR 2 WEEKS.  |
| _____ I HAVE NOT TAKEN ACCUTANE IN THE PAST YEAR.                                  | _____ I AGREE TO NOTIFY DR/AESTHETICIAN OF ANY CONCERNS.   |
| _____ I AGREE NOT TO PICK, PEEL, OR SCRATCH THE SKIN DURING HEALING PHASE.         | _____ I AGREE TO APPLY IMAGE PREVENTION+.  |
| _____ I AGREE THERE MAY BE CRUSTING AND SHEDDING OF SKIN.                          | _____ I AGREE NOT TO WAX FOR 7 DAYS PRE/POST-TREATMENTS.   |
| _____ A PRIOR PATCH TEST HAS BEEN GIVEN TO ME TO RULE OUT ANY ALLERGIC TENDENCIES. | _____ I AGREE TO FOLLOW UP WITH SCHEDULED APPOINTMENT.   |
| _____ I AGREE THAT I CURRENTLY DO NOT USE HYDROCORTISONE.                          | _____ I AGREE NOT TO USE RETIN-A PRODUCTS 7 DAYS PRE/POST-TREATMENTS.                                    |
|  | _____ I AM UNDER THE SUPERVISION OF A PHYSICIAN AND HAVE DISCUSSED THE TREATMENT PLAN WITH MY PHYSICIAN. |

### CONSENT (Please sign)

I hereby give my consent and authorization voluntarily and release \_\_\_\_\_ (Name of business) from any claims, implied or stated that, I have or may have in the future with this treatment, regardless of result. I am stating that the treatment and precautions above have been explained to me in detail and that I fully understand.

**CLIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**WITNESS:** \_\_\_\_\_ **DATE:** \_\_\_\_\_