

CONFIDENTIAL TREATMENT CONSENT

PATIENT/CLIENT INFORMATION

Name _____ Date _____
Address _____
City _____ State _____ Zip _____
Home Phone _____ Work Phone _____
Cell Phone _____ Email _____

TREATMENT (Please Circle One)

SKIN CONDITION (Please Select All That Apply)

SAL-PEEL LACT/KOJIC-PEEL
SAL/GLY-PEEL ENZYME PEEL
MICRO-PEEL GLY/RET-PEEL
MICRODERM TCA PEEL DERMASOUND

SUPERFICIAL WRINKLES, FINE LINES ROSACEA
ACNE OR ACNE PRONE DEHYDRATION
HYPERPIGMENTATION (SUN OR BROWN SPOTS) ACNE SCARS

PRECAUTIONS

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

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

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

Depending on the treatment, you may experience some temporary stinging or warm flushing. 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 2-3 days.

PLEASE INITIAL (Please Read Carefully)

____ I AM NOT PREGNANT.
____ I AM NOT ALLERGIC TO ASPIRIN.
____ I HAVE NOT USED RETIN-A FOR 72 HRS.
____ I DO NOT HAVE ACTIVE COLD SORES.
____ I HAVE NOT TAKEN ACCUTANE IN THE PAST YEAR.
____ I AGREE TO NOT LASER FOR 2 WEEKS.
____ I AGREE TO NOT PICK OR PULL AT THE SKIN.
____ I WILL NOT HAVE ANY OTHER FACIAL PROCEDURE FOR AT LEAST ONE WEEK AFTER TREATMENT.

____ I AGREE TO USE POST PEEL KIT.
____ I AGREE TO AVOID DIRECT SUN EXPOSURE FOR 48 HOURS.
____ I AGREE TO NOTIFY MY ESTHETICIAN OF ANY CONCERS.
____ I AGREE TO APPLY SUNSCREEN DAILY.
____ I AGREE NOT TO WAX FOR 72 HOURS PRE/POST TREATMENT.
____ I AGREE TO TALK WITH THE ESTHETICIAN ABOUT EXERCISE AFTER THE TREATMENT.
____ **POSSIBLE SIDE EFFECTS INCLUDE: REDNESS, IRRITATION, LOCAL SWELLING, MILD DISCOMFORT OR TENDERNESS, PIMPLE-LIKE BUMPS, DRY SKIN, LIGHTENING OR DARKENING OF THE SKIN, INFECTION, SCARRING, PEELING, AND ACTIVATION OF COLD SORES.**

CONSENT (Please Sign)

I hereby give my consent and authorization voluntarily and release **DR. KJAR AND ENHANCE MEDICAL SPA** 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: _____