INFORMED CONSENT: CHEMICAL PEEL & MICRODERMABRASION

PATIENT/CLIENT INFORMATION

Date______________________________ Name____

TREATMENT (Please select one)

❍ Wrinkle Lift Treatment
❍ Micro-Peel
❍ Lightening Lift Treatment
❍ 4 Layer Facelift™ Treatment
❍ Ormedic/Organic Passion Peel

SKIN CONDITION (Please select all that apply)

❍ Superficial wrinkles, fine lines
❍ Acne or acne prone
❍ Hyperpigmentation (sun or brown spots)
❍ Severe photoaging
❍ Rosacea
❍ Dehydration
❍ Acne scars
❍ Unbalanced

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 Professional Grade Peel have been fully explained to me.

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 skin care treatments will determine the outcome. It is important that you strictly adhere to your home care products that our 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. 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 by each statement. (Read carefully)

____ I am not pregnant.
____ I am not allergic to aspirin.
____ I have not used Glycolic for 24 hours.
____ I have not used Retin-A for 72 hours.
____ I have not taken Accutane in the past year.
____ I do not have active cold sores.
____ I have not received radiation treatments.
____ I agree not to pick, peel or scratch the skin during the healing phase.
____ I agree it is mandatory to use the Image Post Peel Kit. (First treatment only.)
____ I agree to avoid direct sun exposure for 2 weeks.
____ I agree to notify my esthetician of any concerns.
____ I agree to apply Image Solar Defense daily.
____ I agree to follow up with scheduled appointment.
____ I agree not to wax the treated area for 7 days pre/post treatment.

I hereby give my consent and authorization voluntarily and release Thursday's 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.

Signature ____ Date____________________

Witness ____ Date____________________

Parent Signature (if under 18)______________________________ Date____________________