

INFORMED CONSENT FOR CHEMICAL PEEL

Prior to receiving treatment, I have been candid in revealing any condition that may have bearing on this procedure, such as: pregnancy/breastfeeding (if so, consult your physician prior to treatment), recent facial surgery, allergies, tendency to cold sores/fever blisters, or use of topical and/or oral prescription medications such as: tretinoin, Retin-A®, isotretinoin, Accutane®, Differin®, Tazorac®, Avage®, EpiDuo® or Ziana®. _____ (Initial)

I understand there may be some degree of discomfort such as stinging, pin-prickling sensation, heat or tightness. _____ (Initial)

I understand there are no guarantees as to the results of this treatment, due to many variables, such as: age, condition of skin, sun damage, smoking, climate, etc. _____ (Initial)

I understand I may or may not actually peel and that each case is individual. I understand that the amount of peeling does not correlate with degree of improvement. _____ (Initial)

I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied. _____ (Initial)

I understand that to achieve maximum results, I may need several treatments. _____ (Initial)

I understand that although complications are very rare sometimes they may occur, and that prompt treatment is necessary. In the event of any complications, I will immediately contact the esthetician and/or office who performed the treatment. _____ (Initial)

I agree to refrain from tanning beds or outdoors while I am undergoing treatment, and during the 14 days prior to and following the end of treatment. This practice should be discontinued due to the increased risk of skin cancer and skin damage. _____ (Initial)

I understand that extended direct sun exposure is prohibited while I am undergoing treatment, and the daily use of sunscreen protection with a minimum of SPF 30 is mandatory. _____ (Initial)

If dermaplaning is part of this treatment, I understand that the sensation and penetration of the peel will be enhanced, which may cause skin irritation, mild discomfort, and tenderness, lightening or darkening of the skin, infection, scarring, dryness and or peeling, and activation of cold sores. _____ (Initial)

I have not had any other chemical peel of any kind within 14 days of this treatment. I understand I cannot have another chemical peel within 14 days of this treatment, whether it is performed at this location or any other location. _____ (Initial)



I understand that I should follow my provider's recommendations for post-procedure skin care to minimize side effects and maximize results. _____ (Initial)

I hereby further agree to all of the above and agree to have this treatment performed on me. I further agree to follow all post-peel care instructions I am directed. _____ (Initial)

I understand that all services that have been rendered are non-refundable and non-transferrable _____ (Initial)

By my signature below, I certify that I have read and fully understand the contents of this permission form. I was given the opportunity to address any question I might have prior to signing this consent and thereby grant permission to perform a treatment by **Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270.** _____ (Initial)

Patient Name _____

Patient Signature _____ Date _____

Witness Name _____

Witness Signature _____ Date _____

Translator Name _____

Translator Signature _____ Date _____

Esthetician Name _____

Esthetician Signature _____ Date _____

CONTINUED TREATMENT CONSENT

Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____