DESERT MEDICAL REJUVENATION
REGAIN YOUR YOUTHFUL APPEARANCE

INFORMED CONSENT FOR DERMAPLANING

I understand that Dermaplaning involves the use of surgical blade to remove fine vellus hair and dead layers of skin from the face. _____**(Initial)**

The nature and purpose of this treatment has been explained to me and any questions I have regarding the treatment have been answered to my satisfaction. _____**(Initial)**

I understand that the treatment may involve the risk of complication or injury and I freely assume those risks._____**(Initial)**

Possible side effects of the treatment area can include mild redness of the skin, irritation and dryness. Additionally, nicks to the skin can occur due to the sharp surgical blade. Patient will be notified, and the area will be treated if necessary. The hair is expected to grow back blunt-ended. New hair will not appear darker or denser. However, I do understand that any hormonal imbalance that may be present within my anatomical system can alter normal hair growth pattern._____**(Initial)**

If a chemical peel 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, peeling, and activation of cold sores. _____**(Initial)**

I agree and adhere to all safety precautions and regulations during the skin treatment. _____**(Initial)**

I have received and understand the post care recommendations are as follows: no sun exposure for 48 hours, moisturize as needed, use gentle cleanser only, Alpha and Beta Hydroxy acid (if desired) may be resumed 48 hours after treatment. Use of sunscreen is highly recommended post-treatment for at least next 7 days. (SPF 30). _____**(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)**

DESERT MEDICAL REJUVENATION 35900 BOB HOPE DRIVE SUITE 130 RANCHO MIRAGE, CA 92270 (760)832-7279 F: (760) 832-7505

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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: _____

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