DESERT MEDICAL REJUVENATION
REGAIN YOUR YOUTHFUL APPEARANCE

INFORMED CONSENT FOR FACIAL

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 that facials may cause temporary redness and/or purging of the pores. There may also be some degree of discomfort such as stinging, pin-prickling sensation, heat or tightness._____**(Initial)**

I understand there are not 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 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)**

I understand that my facial treatment may include clinical-strength products such as enzymes, acid peels, dermaplaning, dermabrasion, extractions, LED therapy and other treatments necessary. These methods will be discussed and agreed upon prior to treatment. _____**(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 questions that I might have prior to signing this consent and thereby grant permission to perform a treatment on me 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_____
TranslatorSignature_____ Date_____

Esthetician Name_____
Esthetician Signature_____
Date_____

CONTINUED TREATMENT CONSENT

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

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