INFORMED CONSENT FOR MICRODERMABRASION

Client/Patient consent for treatment:
My signature acknowledges that I have read and agree to receive the treatments or series of treatments listed below:

I, _____, consent to, and authorize **AESTHETIC MEDICINE SWMT**, or members of his/her staff, to perform Microdermabrasion skin exfoliation and other services.

Areas to be treated: FACE,_____,_____

Estimated # of Treatments: _____

- The nature and purpose of the treatment has been explained to me and any questions I have regarding this procedure have been explained to my satisfaction. _____(initial)
- I know that with any treatment certain risks are involved. These are possible complications or side effects from unknown causes that could occur. I freely assume these risks. _____(initial)
- Possible side effects include but are not limited to: mild redness, extreme redness, bruising, local swelling, stinging, tenderness, dry skin, flaking, lightening or darkening of the skin, infections, pimples, bumpy appearance, and cold sores. Most side effects are temporary and generally subside within 72 hours. _____(initial)
- If I am prone to herpetic outbreaks, I have been advised to see my physician about a prescription for acyclovir, zovirax, or take supplements of L-Lysine, Beta-Carotene and folic acid daily. _____(initial)
- I have been advised to discontinue all AHA's, Glycolics, Retin-A, Renova, or any exfoliating products for 72 hours pre or post procedure. I understand that I must use hydrating and soothing antioxidants for healing and ice for swelling of inflammations reduction. I understand there should be no sun exposure for 72 hours. I will use a broad-spectrum sunscreen at all times for the duration of my treatment(s). _____(initial)
- I have been advised to avoid collagen injections for up to 10-14 days prior to any Microdermabrasion treatment and 7 days after. _____(initial)
- I agree to adhere to all safety precautions and the home skincare regiment suggested by my practitioner. _____(initial)
- I am over 18 years of age or have parental consent signed below. _____(initial)
- I will call to inform my practitioner of any complications or concerns I may have as soon as they occur. _____(initial)

Date: _____

Patient Signature:_____

Parent or Guardian Signature: _____

Post procedure instructions given_____