Dr. R. van Aardt
Cosmetic Medicine

DERMAPLANING CONSENT

Date:_____

Name: Date of Birth:

Please read the following and acknowledge that you understand and accept all provisions by initials and signature.

_____ I understand that the goal of this treatment is the removal of superficial hair and minimal exfoliation.

_____ I understand that this procedure uses a Dermaplaning blade, which is mildly abrasive, therefore I will follow the explicit instructions of my skin care professional.

_____ I have been advised of alternate methods available for my treatment, which include acid peels and waxing treatments.

_____ The nature and purpose of the treatment have been explained to me, and any question I have regarding this procedure has been explained to my satisfaction,

_____ I understand that my Service Provider can discover other, or difficult conditions that may require additional or different procedures than those planned. If my skin care professional discover such other, or different conditions I will be referred to an appropriate medical provider.

_____ I acknowledge that the practice of cosmetology is not an exact science and that no specific guarantees can or have been made concerning the expected result. Some clients are improved and in others no appreciable improvement noticed.

_____ I understand that with any treatment certain risks are involved and that any complications or side effects from known or unknown causes could occur. I freely assume these risks.

_____ I acknowledge my obligation to follow the written and spoken instructions covering my pre- and post-treatment skin care regime.

_____ I understand that multiple treatments may be required. The cost of these has been discussed prior to the first treatment.

_____ I agree to all safety precautions and home skin care programs as recommended by my skin care professional.

_____ I understand that payment of this treatment is non-refundable and that I will not hold anyone at this Medi-Spa responsible if this course of treatment is not to my satisfaction.

I am over 18 years of age or I have parental consent co-signed below. I will call to inform my Service Provider of any complications or concerns as soon as they occur. I agree to receive the treatment or series of treatments as outlined by my Service Provider.

I certify that I have read the above consent and that I fully understand it. I have been given ample opportunity for discussion and all my questions have been answered to my satisfaction. I hereby consent to the Dermaplaning treatment.

Print Client/Parental Name	Client/Parental Consent Signature	Date
Print Service Provider Name	Service Provider Signature	Date