Dr. R. van Aardt
Cosmetic Medicine

MICRODERMABRASION CONSENT

Name: _____ Date of Birth: _____

Contact Tel # (Cell): _____-_____-_____ (W): _____-_____-_____ (H): _____-_____-_____

Email: _____ Consent to use: __Y __N

Address:

Please initial and sign below:

____ I am not currently wearing contact lenses. If YES, they need to be removed for the treatment.

____ I have been off glycolic, AHA's and Retinol products for 48 hours.

____ I shall not use any suntan beds for at least 2 weeks after a treatment.

____ Microdermabrasion is used to diminish the appearance of hyper pigmentation, fine lines and other skin conditions.

____ After a treatment the skin may feel tight, as if exposed to sun or wind. Most side effects are temporary and generally subside within 72 hours. Possible side effects (not probable) may include slight redness, extreme redness, swelling, bruising, stinging, tenderness, dry or flaking skin, lightening or darkening of the skin. If these occur healing may take up to 14 days.

____ Anytime the skin barrier is broken there is small risk of bacterial or viral infection.

____ Your fresh, newly exposed skin will be delicate. Protection is required with a moisturizing sun block. Keep the area clean and dry. For the best benefit of the treatment leave regular makeup off for 3-24 hours.

____ It is important to note that wrinkles, freckles and other age spots are cosmetic in nature and pose no medical threat if they are not treated. Therefore, Microdermabrasion is an elective, cosmetic procedure and should be done with these considerations in mind.

____ I acknowledge that no guarantee has been given to me as to the condition of my skin, pore size, wrinkles or the percentage of improvement following treatments. I understand that no specific results are guaranteed.

____ For the purposes of accurate record keeping in connection with the care and treatment which I am receiving and will subsequently receive from this clinic, I, the undersigned, consent to have this clinic's staff take before, during, and after treatment close-up photographs of the involved area(s) and the anatomical region surrounding the involved area(s). These photographs shall be used for medical records and shall be treated with the same confidentiality as the remainder of my record at this clinic.

____ I hereby consent that my photographs may discreetly be used by this clinic for promotional material.

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

By signing below: I acknowledge that I have read this document and agree to the treatment with its associated risks. I voluntarily consent and authorize that this Parisian Peel treatment may be performed by the staff of this clinic, including physicians, technicians, associates, technical assistants, and other health care providers as deemed necessary by the Service Providers of this clinic.

_____	_____	_____
Print name of Client	Signature of Client	Date
_____	_____	_____
Print name of Service Provider	Signature of Service Provider	Date