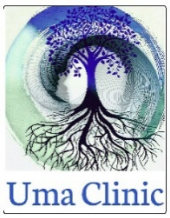

CHEMICAL PEEL CONSENT FORM

Name: _____DOB: _____ Date: _____
Address: _____ State: _____ Zip: _____
Cell Phone: _____ Email: _____Birthday: _____

Skin Conditions: (please circle all that apply)

Superficial Wrinkles/Fine Lines	Dehydration	Deep hyperpigmentation (sun or brown spots)
Rosacea	Acne Scars	
Deep Wrinkles	Unbalanced	
Acne or Acne Prone	Severe Photo Aging	

Do you have any specific problems/ areas you would like to focus on? Please explain: _____
_____
_____

Precautions: (please read carefully)
The Treatment you will receive is a clinical treatment designed to exfoliate or remove the outer layers of the skin.
Your Participation in your skin care treatments will determine the outcome. It is important that you strictly adhere to your home care products your esthetician has recommended.
No Guarantee is expressed or implied as to the precise results, peeling times or discomfort.
During the Treatment, you may experience some temporary stinging or warm flushing. This will fade within a few minutes. During the next few hours, you may experience some tightening of the skin, which may last several days.
For Most Patients, flaking begins within 48 hours. It is possible to pre-determine how much peeling will occur. The shedding process usually subsides within 5-7 days.
Depending on the clinical peel performed and your skin quality, the following reactions might occur.
1.) Prolonged redness 2.) Dryness and sensitivity 3.) Severe allergic reaction in rare instances

Treatment: (please initial by each statement)
____ The treatment was explained to me in detail
____ The benefits of what I can realistically expect to see from my Chemical Peel have been fully explained to me

Please Initial: (read carefully)
_____ I am not pregnant
_____ I am not allergic to Aspirin
_____ I have not used Glycolic products for 24 hours
_____ I have not used Accutane in the last year
_____ I agree to apply the proper SPF recommended to me by my esthetician
_____ I agree not to pick, peel or scratch the skin during the healing phase
_____ I agree to follow up with my scheduled appointment
_____ I agree that I am aware of possible crusting and shedding of the skin
_____ I have not used retinol products in 72 hours
_____I agree that I have not used Retin-A or any Vitamin A derivatives in the week before the procedure
_____ I agree not to use Retin-A or any Vitamin A derivatives for the next week following the procedure
_____ I agree that I currently do not use Hydroquinone
_____ A patch test has been given to me to rule out any allergic responses
_____ I do not have any active cold sores
_____ I have not received any chemotherapy/ radiation treatment within the last 6 months
_____ I agree its mandatory to use the Post Peel Kit my esthetician has given to me
_____ I agree to avoid prolonged sun exposure for the next 2 weeks following treatment
_____ I agree to notify my esthetician of any problems or issues following treatment
_____ I agree not to wax or use any type of depilatories for one week following treatment

I hereby give consent and authorization voluntarily and release from any claims, implied or stated that I have or may have in the future with this treatment, regardless of result. I am stating that the treatment and precautions above have been explained to me in detail and that I fully understand.

Client Signature: _____**Date**: _____

Licensed Master Esthetician: _____ **Date**: _____