MICRODERMABRASION CONSENT FORM

Prior to receiving this treatment, I have been candid in revealing any condition that may have a bearing on this procedure, such as, pregnancy, recent facial peels or surgery, allergies, tendencies to cold sores and fever blisters, use of Retin-A, Accutane or Hormones.

I understand there may be some degree of minor discomfort, i.e., scratchiness, itchiness. I understand there are no guarantees to this procedure.

I understand that to achieve maximum results, I will need several ongoing treatments and will need to use a daily product over a period of time.

I understand that the possibility of irritation and redness exists and that I should notify my skin care pro- fessional when irritation persists.

I will follow the home care program specifically designed for me without changing or adding any prod- ucts without consulting with my skin care professional.

I have read the enclosed consultation and understand the contents.

I AGREE TO ALL OF THE ABOVE TO HAVE THIS TREATMENT PERFORMED ON ME AND WILL FOLLOW ALL PRESCRIBED DIRECTIONS REGARDING POST PEEL CARE.

_____ _____

Patient or Person Authorized to Sign for Patient

Please Print Name Here

DATE: _____ **WITNESS:** _____