Chemical Peel Informed Consent

Patient Number:________

Name:_________________

Prior to receiving treatment, I have been candid in revealing any conditions that may have bearing in this procedure, such as: pregnancy (if so, consult your physician prior to treatment), recent facial surgery, allergies, tendency to cold sores/fever blisters, use of Retin-A®, Accutane®, Differin®, Tazorac® or Avage®.

I understand there may be some degree of discomfort: i.e., stinging, pinpricking sensation, hotness, or tightness.

I understand there are no guarantees as to the results of this treatment, due to many variables, such as: age, condition of skin, sun damage, smoking, climate, etc. I understand I may not actually peel, that each case is individual.

I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied.

I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complication, I will immediately contact the doctor/technician who performed the treatment.

Although all precautions and proper procedures are strictly followed, I understand that during and after my chemical peel I may experience one or several of the following: discomfort, swelling, reddening, change in color texture and/or pigmentation between the area treated and not treated, darkening of existing blemishes, the occurrence of milia, eye injury and infection.

Should one or more of the foregoing complications arise, please notify the office immediately. Early detection and treatment may minimize future complications.

I understand that sun exposure and tanning is prohibited while I am undergoing treatment and that the use of sunblock protection with a minimum of 30 SPF or higher is recommended by AWC.

I declare that I have not had any other chemical peel of any kind, within 14 days of the treatment. I understand I cannot have another treatment within 14 days of this treatment, whether it is performed at this location or any other location.

I understand that I must remove my contact lenses from my eyes before having this treatment.

I hereby agree to all of the above and agree to have this treatment performed on me. I further agree to follow all post-peel care instructions as I am directed.

Patient Signature:____

Verify Initials:____________________ Date:__________________

Signature of Technician:____

Continued Treatment Consent

Date	Treatment	Patient Initials	Tech. Initials