IMAGE SKINCARE

INFORMED CONSENT FOR IMAGE TREATMENTS

PATIENT/CLIENT INFORMATION

DATE _____
NAME _____
ADDRESS _____
CITY/STATE/ZIP _____

HOME PHONE _____
WORK PHONE _____
CELL _____
EMAIL _____
FAX _____

TREATMENT (Please initial by each statement)

_____ The treatement was explained to me in detail.
_____ The benefits of what I can realistically expect to see from my Clinical Peel have been fully explained to me.

TREATMENT (Please select one)

_____ ORMEDIC LIFT
_____ SIGNATURE LIFT
_____ LIGHTENING LIFT
_____ WRINKLE LIFT
_____ ACNE LIFT
_____ ACNE ADVANCED LIFT
_____ IMAGE PERFECTION LIFT
_____ TCA ORANGE LIFT

SKIN CONDITION (Please select all that apply)

_____ SUPERFICIAL WRINKLES, FINE LINES
_____ DEEP WRINKLES, FINE LINES
_____ ACNE OR ACNE PRONE
_____ DEEP HYPERPIGMENTATION (SUN OR BROWN SPOTS)
_____ SEVERE PHOTOAGING
_____ ROSACEA
_____ DEHYDRATION
_____ ACNE SCARS
_____ UNBALANCED

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 that 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 for several days.

For most patients, flaking begins within 48 hours. It is impossible 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 may occur in some patients:
1) Prolonged redness, irritation & flakiness 2) Dryness and sensitivity 3) Severe allergic reactions in rare instances

PLEASE INITIAL (Please Read Carefully)

_____ I AM NOT PREGNANT.**
_____ I AM NOT ALLERGIC TO ASPIRIN.
_____ I HAVE NOT USED GLYCOLIC FOR 24 HRS.
_____ I HAVE NOT USED RETINOL PRODUCTS FOR 72 HRS.
_____ I HAVE NOT TAKEN ACCUTANE IN THE PAST YEAR.
_____ I AGREE NOT TO PICK, PEEL, OR SCRATCH THE SKIN DURING HEALING PHASE.
_____ I AGREE THERE MAYBE CRUSTING & SHEDDING OF SKIN.
_____ A PRIOR PATCH TEST HAS BEEN GIVEN TO ME TO RULE OUT ANY ALLERGIC TENDENCIES.
_____ I AGREE THAT I CURRENTLY DO NOT USE HYDROCORTISONE.
_____ I DO NOT HAVE ACTIVE COLD SORES.
_____ I HAVE NOT RECEIVED RADIATION TREATMENTS.
_____ I AGREE IT IS MANDATORY TO USE IMAGE POST PEEL KIT.
_____ I AGREE TO AVOID DIRECT SUN EXPOSURE FOR 2 WEEKS.
_____ I AGREE TO NOTIFY DR/AESTHETICIAN OF ANY CONCERNS.
_____ I AGREE TO APPLY IMAGE DAILY DEFENSE DAILY.
_____ I AGREE NOT TO WAX FOR 7 DAYS PRE/POST TREATMENT.
_____ I AGREE TO FOLLOW UP WITH SCHEDULED APPOINTMENT.
_____ I AGREE NOT TO USE RETIN-A PRODUCTS 5 DAYS PRE/POST TREATMENTS
_____ I AM UNDER THE SUPERVISION OF A PHYSICIAN AND HAVE DISCUSSED THE TREATMENT PLAN WITH MY PHYSICIAN.

CONSENT (Please sign)

I hereby give my consent and authorization voluntarily and release _____ (Name of business) 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:** _____

WITNESS: _____ **DATE:** _____