Informed Consent

Informed Consent for Chemical Exfoliation Treatment

Please read and initial after each statement.

_____ I have been given the Skin Care History Questionnaire and have read and answered the questions thoroughly.

_____ I have discussed any further questions or concerns that I may have as well as time frames for anything that must be avoided post treatment with my Skin Care Specialist.

_____ My Skin Care Specialist has answered any questions I have regarding my post care. I acknowledge my obligations to closely follow the post care instructions and visit my Skin Care Specialist for a post treatment follow-up as specified.

_____ I am aware and acknowledge that there is a rare possibility of an allergic reaction. I have discussed thoroughly with my Skin Care Specialist any such reactions and understand them.

_____ I have had a patch test and it is negative. In the event of any complications, I will immediately contact the Skin Care Specialist who performed the treatment.

_____ I am willing to forego a patch test but understand there could be an allergic reaction.

_____ I have been advised that my treatment is a non-invasive, light exfoliation consisting singly, or a combination of Salicylic Acid, Lactic Acid, Glycolic Acid, Resorcinol, Trichloracetic Acid, Retinoic Acid and Enzymes.

_____ The use of the above ingredients stimulates the skin to generate new skin cells. It does not replace deep chemical peel, laser resurfacing or plastic surgery.

_____ I acknowledge that there may be some degree of discomfort during application. I will notice a warm sensation and the skin may tingle or sting and I may feel pin pricking, heat (burn) or tightness. Immediately after the chemical exfoliation treatment, my face may appear frosted or red, and by day two (2), the skin may darken in color, feel tighter, and be more sensitive. Days two (2) through seven (7), the skin may exfoliate. I am not to pick or peel skin. Pulling or picking skin may lead to infection, hyperpigmentation and/or surface scars. I may experience some breaking out after a treatment.

_____ I acknowledge that I will avoid direct sun exposure following this procedure and will apply a sunscreen daily.

_____ Chemical Exfoliation treatments may lighten hyperpigmented skin, reduce acne breakouts or diminish fine lines. I acknowledge that there is **NO GUARANTEED** result. I am aware that there could even be an increase of uneven color from this procedure.

_____ I acknowledge that I have not been using Accutane, Differin®, Azelex®, Finacea™, Tazorac® or any other prescribed medication(s) for the past two weeks.

_____ I acknowledge that I am prone to cold sore (Herpes Simplex). I may need a prescription for Denavir®, Zovirax® or Abreva from my physician prior to having a chemical exfoliation treatment. I am aware the treatment could prompt cold sores.

_____ I acknowledge that I am not aspirin sensitive. If I am aspirin sensitive, I have discussed this with my Skin Care Specialist and understand there could be a reaction.

_____ I acknowledge that to achieve maximum results, I may need several treatments and should use home care products.

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

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

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

_____ _____

CLIENT SIGNATURE DATE

_____ _____

SKIN CARE SPECIALIST SIGNATURE DATE

Skin Care History Questionnaire and Waiver

Please answer the following questions so that your Skin Care Specialist may have a better understanding of your general health and lifestyle, thereby enabling your Skin Care Specialist to accurately analyze and assess your skin care needs.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Date of Birth: _____

E-mail address: _____

Health History

What type of work do you do? _____

Have you seen a dermatologist in the past year? Yes_____No_____

If yes, list dermatologist's name, contact info and reason for visit _____

_____

Are you presently under a physician's care? Yes_____ No_____

If yes, list physician's name and reason for visit _____

_____

Are you currently taking any medications? Yes_____ No_____ If yes, please list _____

_____

What is your genetic background? _____

How is your general health? _____ Excellent _____ Good _____ Fair _____ Poor

Please rate your stress level from 1-5 (5 being the highest): _____

Please see Contraindications, page 44. Contact dermatologist to confirm treatment.

Please see Contraindications, page 44.

Please circle the following conditions you have or had experienced:

- hypertension
- metal plate
- diabetes
- fainting
- cold sores
- hernia
- stroke
- contact lenses
- anemia
- lupus
- irregular pulse
- claustrophobia
- cancer
- thyroid disorders
- high cholesterol
- varicose veins
- seizures
- eating disorder
- heart attack
- epilepsy
- headaches
- asthma
- hepatitis
- tooth fillings
- high/low blood pressure
- autoimmune disorder

These conditions may just need to be known or are a contraindiction to treatment. If treatment is questionable, contact a physician.

Do you take nutritional supplements? Yes_____ No_____

Do you exercise? Yes_____ No_____

Do you have a tendency to scar? Yes_____ No_____

Allergies:

Have you ever had an allergic reaction to any of the following:

ASPIRIN OR SALICYLATES Yes_____ No_____

MILK Yes_____ No_____

APPLES Yes_____ No_____

CITRUS Yes_____ No_____

GRAPES Yes_____ No_____

INGREDIENTS IN SKIN CARE PRODUCTS Yes_____ No_____

FISH, MARINE OR IODINE ALLERGIES Yes_____ No_____

LATEX Yes_____ No_____

If known allergy, refer to ingredient decks and perform patch test.

If checked yes to any of the above, please explain _____

_____

_____

Please list any other known allergies:

_____

Have you ever had Herpes Simplex? Yes_____ No_____

If yes, have you ever been treated with Denavir® (Penciclovir), Zovirax® (Acyclivor) or Abreva?

Yes_____ No_____

Are you being treated for Hepatitis? Yes_____ No_____

Consult with a physician, proper medication may be needed or may be contraindicted.

Female clients only:

Are you on hormone replacement therapy? Yes_____ No_____

Are you presently taking birth control pills? Yes_____ No_____

Are you pregnant or nursing? Yes_____ No_____

Skin Care History

Are you currently having skin treatments? Yes_____ No_____

If yes, what type of treatment(s)_____

Please check if you are presently using or have used in the past any of the following:

_____ Benzoyl Peroxide (BP)

_____ Glycolic Acid (AHA)

_____ Lactic Acid (AHA)

_____ Resorcinol

_____ Salicylic Acid (BHA)

Do you have or have you had any of the following in the last 14 days?

_____ Facial Cosmetic Surgery
_____ Botox Injections
_____ Collagen Injections
_____ Fillers
_____ Light Treatments
_____ Laser Resurfacing
_____ Microdermabrasion
Other _____

Higher risk of contraindiction.

HOME CARE:

What skin care products are you currently using at home?

Use of proper home care products are crucial to results. Incorporate pre and post treatment products.

Cleanser _____
Toner _____
Moisturizer _____
SPF _____
Vitamin C _____
Exfoliants/Scrubs _____
Specialty Products _____
Mask _____

PRESCRIPTION PRODUCTS:

_____ Tretinoin (Retin A, Retin-A Micro®, Renova, Avita)
_____ Adepalene (Differin®)
_____ Azelaic Acid (Azelex®, Finacea™)
_____ Tazarotene (Tazorac®)
_____ Isotretinoin (Accutane)
_____ Triluma™
_____ Metrogel

Consult with a physician, as treatment may be contraindicted.

Any other topical antibiotics _____

PLEASE CHECK IF YOU ARE PRESENTLY EXPERIENCING OR HAVE EXPERIENCED ANY OF THE FOLLOWING:

_____ Skin Cancer
_____ Dermatitis
_____ Keloid Scarring
_____ Acne
_____ Rosacea
_____ Broken Capillaries
_____ Treatment Reactions
_____ Hypopigmentation
_____ Hyperpigmentation

Confirm whether prescription, OTC or retail products are at proper levels, certain ingredients are needed while others may cause sensitivity or reaction at high concentrations.

SUN PROTECTION:

Do you use a sunscreen? Yes_____ No_____
What level of protection? _____
Do you sunbathe or participate in outdoor activities? Yes_____ No_____
Do you tan in a tanning booth? Yes_____ No_____
Have you tanned in a tanning booth in the last 14 days? Yes_____ No_____
Have you had any direct sun exposure in the last 10 days? Yes_____ No_____

Chemical exfoliant treatments make skin sun sensitive. SPF is highly recommended.

WHEN EXPOSED TO THE SUN DO YOU:

_____ Always burn, never tan
_____ Always burn, sometimes tan
_____ Sometimes burn, sometimes tan
_____ Always tan

Helps determine Fitzpatrick Skin Type.

Do you feel your skin is sensitive? Yes_____ No_____

WHAT SKIN CONDITIONS DO YOU WANT TO IMPROVE?

_____ Acne and/or breakouts
_____ Facial Scarring
_____ Hyperpigmentation (freckles, age spots)
_____ Hypopigmentation
_____ Enlarged Pores
_____ Fine Lines and Wrinkles

Helps esthetician understand expectations and create treatment plan.

OTHER _____

Is there any other necessary information your Skin Care Specialists should know before beginning your treatment? Yes_____ No_____

If yes, please explain _____

_____

I have acknowledged that all the information provided by me is true and correct to the best of my knowledge. I understand that some skin conditions may require more than one treatment and home care products to achieve the result desired. Results cannot be guaranteed due to individual skin type(s) and condition(s). I understand I need to sign this waiver prior to every treatment provided, with ANY changes pertaining to the above questionnaire.

Client Signature: _____ **Date:** _____
Client Signature: _____ **Date:** _____
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Client Signature: _____ **Date:** _____
Client Signature: _____ **Date:** _____

Have client review and sign before each appointment to acknowledge there have not been any changes.

○ Please check if permission is granted to use pictures for marketing and training purposes. Your name will remain anonymous.

Take pictures before and after treatment to monitor progress and for proper documentation.

Skin Care History Questionnaire and Waiver

Please answer the following questions so that your Skin Care Specialist may have a better understanding of your general health and lifestyle, thereby enabling your Skin Care Specialist to accurately analyze and assess your skin care needs.

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Date of Birth: _____

E-mail address: _____

Health History

What type of work do you do? _____

Have you seen a dermatologist in the past year? Yes_____ No_____

If yes, list dermatologist's name, contact info and reason for visit_____

_____

Are you presently under a physician's care? Yes_____ No_____

If yes, list physician's name and reason for visit _____

_____

Are you currently taking any medications? Yes_____ No_____ If yes, please list _____

_____

What is your genetic background? _____

How is your general health? _____ Excellent _____ Good _____ Fair _____ Poor

Please rate your stress level from 1-5 (5 being the highest): _____

Please circle the following conditions you have or had experienced:

- hypertension
- metal plate
- diabetes
- fainting
- cold sores
- hernia
- stroke
- contact lenses
- anemia
- lupus
- irregular pulse
- claustrophobia
- cancer
- thyroid disorders
- high cholesterol
- varicose veins
- seizures
- eating disorder
- heart attack
- epilepsy
- headaches
- asthma
- hepatitis
- tooth fillings
- high/low blood pressure
- autoimmune disorder

Do you take nutritional supplements? Yes_____ No_____

Do you exercise? Yes_____ No_____

Do you have a tendency to scar? Yes_____ No_____

Allergies:

Have you ever had an allergic reaction to any of the following:

ASPIRIN OR SALICYLATES Yes_____ No_____

MILK Yes_____ No_____

APPLES Yes_____ No_____

CITRUS Yes_____ No_____

GRAPES Yes_____ No_____

INGREDIENTS IN SKIN CARE PRODUCTS Yes_____ No_____

FISH, MARINE OR IODINE ALLERGIES Yes_____ No_____

LATEX Yes_____ No_____

If checked yes to any of the above, please explain _____

_____

_____

Please list any other known allergies:

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Have you ever had Herpes Simplex? Yes_____ No_____

If yes, have you ever been treated with Denavir® (Penciclavir), Zovirax® (Acyclivor) or Abreva?

Yes_____ No_____

Are you being treated for Hepatitis? Yes_____ No_____

Female clients only:

Are you on hormone replacement therapy? Yes_____ No_____

Are you presently taking birth control pills? Yes_____ No_____

Are you pregnant or nursing? Yes_____ No_____

Skin Care History

Are you currently having skin treatments? Yes_____ No_____

If yes, what type of treatment(s) _____

Please check if you are presently using or have used in the past any of the following:

_____ Benzoyl Peroxide (BP)

_____ Glycolic Acid (AHA)

_____ Lactic Acid (AHA)

_____ Resorcinol

_____ Salicylic Acid (BHA)

FORMS

Do you have or have you had any of the following in the last 14 days?

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_____ Botox Injections
_____ Collagen Injections
_____ Fillers
_____ Light Treatments
_____ Laser Resurfacing
_____ Microdermabrasion

Other _____

HOME CARE:

What Skin care products are you currently using at home?

Cleanser _____
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Moisturizer _____
SPF _____
Vitamin C _____
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PRESCRIPTION PRODUCTS:

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_____ Tazarotene (Tazorac®)
_____ Isotretinoin (Accutane)
_____ Triluma™
_____ Metrogel

Any other topical antibiotics _____

PLEASE CHECK IF YOU ARE PRESENTLY EXPERIENCING OR HAVE EXPERIENCED ANY OF THE FOLLOWING:

_____ Skin Cancer
_____ Dermatitis
_____ Keloid Scarring
_____ Acne
_____ Rosacea
_____ Broken Capillaries
_____ Treatment Reactions
_____ Hypopigmentation
_____ Hyperpigmentation

SUN PROTECTION:

Do you use a sunscreen? Yes_____ No_____
What level of protection? _____
Do you sunbathe or participate in outdoor activities? Yes_____ No_____
Do you tan in a tanning booth? Yes_____ No_____
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WHEN EXPOSED TO THE SUN DO YOU:

_____ Always burn, never tan
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Do you feel your skin is sensitive? Yes_____ No_____

WHAT SKIN CONDITIONS DO YOU WANT TO IMPROVE?

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OTHER _____

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Client Signature: _____ **Date:** _____

○ Please check if permission is granted to use pictures for marketing and training purposes. Your name will remain anonymous.

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CLIENT'S NAME: _____ DATE: _____

CLIENT'S CURRENT SKIN CARE PRODUCTS: _____

_____

TREATMENT PROVIDED _____

AREA TREATED: _____ HOW MANY LAYERS / TIME LEFT ON SKIN: _____

PRODUCT USED TO PREP SKIN: Peel Prep Enzyme Glycolic 30% NEUTRALIZED: Yes No

MASK: None Soothing Gel Mask Calming Seaweed Mask Restorative Mask Refining Mask

ADDITIONAL PRODUCTS USED: _____

RESULTS: Redness Hot Spots Frosting Other

COMMENTS: _____

CLIENT'S NAME: _____ DATE: _____

CLIENT'S CURRENT SKIN CARE PRODUCTS: _____

_____

TREATMENT PROVIDED _____

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CLIENT'S CURRENT SKIN CARE PRODUCTS: _____

_____

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