AESTHETIC MEDICAL
NETWORK

Patient Consent Form – CHEMICAL PEEL

Patient Name: _____Date: _____

1. I have been candid in revealing any condition that could prohibit this treatment such as coldsores, pregnancy, use of hormones, recent facial surgery or laser resurfacing, recent use of Retin A, retinol, benzoyl peroxide, AHA, BHA within the last 1 week or use of Accutane within the last twelve months.
2. I understand that there are no guaranteed results from this treatment. Many variables exist such as age, sun damage, on-going sun exposure, smoking, excessive alcohol intake, climate, diet and water intake, skin thickness and sensitivity.
3. I understand that I may or may not peel and that each case is individual.
4. Regardless of precautions taken, I acknowledge the possibility of an adverse reaction to the peel and accept sole responsibility for any medical care that may become necessary. I will immediately contact the physician performing the treatment of any adverse reactions.
5. I will not scratch, pick, pull at or abrade the treated skin.
6. I understand that direct sun exposure and use of a tanning booth is prohibited 2 weeks before and 2 weeks after treatment time, and the use of sunscreen with a minimum SPF 15 sun protection daily is mandatory.
7. I understand that to achieve maximum results the recommended home care routine must be followed. I understand that if I alter the routine or use products not recommended by the skin care professional the results could be altered or inhibitive.
8. I understand that it may take several treatments to obtain the desired results.
9. I understand that the following side effects or complications can occur: Discomfort, Redness and swelling, Hypopigmentation or light spots, Itching or irritation, Skin peeling or flaking up to 14 days after the procedure, Infection, Scarring, Hyperpigmentation or dark spots, Acne Breakouts. Should one or more of the foregoing complications arise, please notify us immediately. Early detection and treatment may minimize the extent of a complication.
10. I understand the goals of the treatment as well as the limitations and possible complications.
11. My Skin Specialist has provided the information and has answered all my questions concerning this procedure. I clearly understand the above information.
12. I have read and understand the Pre and Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre- and post- procedure guidelines are crucial for healing, prevention of side effects and complications as listed above.
13. I have advised my physician if I am pregnant, trying to get pregnant or if I am nursing. I understand and agree that all services rendered to me are charged to me directly and that I am personally responsible for payment. No refunds for products and services. The nature and purpose of the treatment has been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.
14. I release Aesthetic Medical Network, medical staff, and specific technicians from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

Patient's Signature: _____Date: _____

Physician’s Signature: _____Date: _____