Your WELLNESS CENTER

DERMAPLANE CONSENT

Please initial each line:

_____Dermaplaning is a form of manual exfoliation similar in theory to microdermabrasion but without the use of suction or abrasive crystals. An esthetician grade, sterile blade is stroked along the skin at an angle to gently "shave off" dead skin cells from the epidermis. Dermaplaning also temporarily removes the fine vellus hair of the face, leaving a very smooth surface. As with any type of exfoliation, the removal of dead skin cells allows home care products to be more effective, reduces the appearance of fine lines, evens skin tone and assists in reducing milia, closed and open comedones, and minor breakouts associated with congested pores. Due to the contours of the face, certain areas of the face (such as the eyelids and nose) are not treatable using this method. Maximum results are obtained by participating in a series of treatments plus following a home care regimen.

_____ I acknowledge that I do not have any of the contraindications listed below:

- Acne- severe or cystic
- Active infection of any type, such as herpes simplex
- Any raised lesions
- Chemical peel procedure within 2 weeks
- Chemotherapy or radiation
- Eczema or dermatitis
- Family history of hypertrophic scarring or keloid formation
- Hemophilia
- Hormonal therapy that produces thick pigmentation
- Moles
- Oral blood thinner medications
- Recent use of Retin-A
- Rosacea-severe
- Scleroderma-severe
- Skin Cancer
- Sunburn
- Tattoos
- Telangiectasia/redness-severe
- Thick, dark facial hair
- Uncontrolled diabetes
- Use of Accutane within the last year
- Vascular lesions

_____I acknowledge that if I am prone to cold sores or fever blisters, the treatment may stimulate an outbreak so pre-use medication to help avoid a possible breakout is recommended.

_____I acknowledge I should avoid aggressive exfoliation, waxing, and Retin-A products for one week following the treatment.

_____I acknowledge my skin may experience irritation, tightness, and/or redness which usually dissipates within 24 hours.

_____ I acknowledge that if I fail to use sunscreen, I am more susceptible to sunburn, sun damage, and hyperpigmentation.

_____ **I acknowledge that if I am pregnant or breastfeeding I must inform my provider prior to my treatment. There are no contraindications for the act of dermaplaning with a medical blade. However, topical products, peels, and masks applied to the skin after the dermaplaning may contain ingredients not suitable for the skin during pregnancy and breastfeeding. Any products unsafe will be withheld during the treatment.**

_____ I acknowledge that I do not have any allergies to the following ingredients in the Jelly Masks

- Avena Sativa (oats)
- Raspberry
- Salicylic
- Tea Tree Oil
- Sage
- Clay
- Eucalyptus Oil
- Silika
- Willow Bark
- AHA
- Peppermint Oil
- Fragrance
- Alage

For any questions regarding ingredients or allergies, please ask your provider for a full ingredient list.

_____ DISCLAIMER: I understand the nature of the procedure to be performed, the contraindications, side effects, risk, and complications. I acknowledge that I have been given the opportunity to ask any questions regarding the procedure, and these questions have been answered to my satisfaction. I understand the pre and post care instructions and how crucial they are for the success of dermaplaning treatments. By not following the pre and post care instructions, I understand side effects and complications may occur. Although good results are expected, there is no guarantee on the results that may be obtained. I hereby give my unrestricted informed consent for the procedure and subsequent treatments. I hereby release the providers and the facility from liability associated with this procedure. I am aware this is a cosmetic procedure and I am fully responsible to pay for the entire amount charged. I understand no refunds for any treatment may be rendered, regardless of the results. I understand it is my responsibility to inform the office staff of any medical changes that have occurred, including any contraindications to the list above.

Printed Patient's Name: _____

Patient's Signature: _____ Date: _____