Progressive Laser LLC

"Science enhancing Beauty..."

Replenix MD Perfect 10 Peel Consent and Release Form

Please read carefully, complete, sign and date this form prior to your procedure.

Name: ____ **Phone:** ________________________

- My Esthetician has answered any questions I have regarding the procedure and my aftercare. I acknowledge my obligations to closely follow aftercare instructions and visit my esthetician for post peel treatment if specified. **(Patient Initial)** ________
- I acknowledge that during the application I will notice a warm sensation and that my skin may tingle, sting or burn. Immediately after the peel my face may appear frosted or sunburned. By day two, the skin may darken in color, feel tighter and become more sensitive. On days two through seven the peeling process begins. I am not to pick or peel at the old skin. Pulling or picking the skin may lead to infection or scarring. I may experience breakouts during this process. **(Patient Initial)** ________
- I have been advised that my treatment is non-invasive, epidermal exfoliation. The procedure stimulates the skin to generate new skin cells, produce new collagen, and increase the blood flow circulation of the skin. **(Patient Initial)** ________
- Scarring, scabbing and long term pigmentary changes are possible risks involved in chemical peels and are more likely when people have not been honest about pre-treatment exposure to sun. I understand that I must use a full spectrum sub block with an SPF minimum of 30 daily. **(Patient Initial)** ________
- I acknowledge that I have not been on Accutane during the past 6 months. I acknowledge that I have not used Retin-A or Reonva for the past two weeks. I will also avoid the use of Retin-A, Renova, all forms of scrubs, alpha and beta hydrozyl type products for 14 days or until my sensitivity has subsided. **(Patient Initial)**_______
- I acknowledge that if I am prone to cold sores (herpes) I may need a prescription from my physician prior to having a peel. I am aware that the treatment could bring about cold sores.**(Patient Initial)**_____
- I acknowledge that I am not Asprin sensitive or if I am I have discussed this with my skin care specialist and understand that there could be a reaction. **(Patient Initial)** ________
- I hereby authorize *Progressive Laser* to take pictures of the treated area in my confidential patient file. I understand that this information will be kept confidential and that no patient names will be used. **(Patient Initial)** ________

I authorize _______________________ at Progressive Laser to perform this chemical peel treatment. I understand that this procedure works on promoting vibrant and healthy looking skin. I understand that multiple treatments are required in order to see significant results.

Patient Signature___________________________________Date: ____________________
Technician signature _________________________________Date: ____________________

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