Progressive Laser LLC

INFORMED CONSENT: DERMAPLANING

Dermaplaning is a simple, quick, and safe procedure for exfoliating the epidermis and ridding the skin of fine vellus hair (peach fuzz) by shaving the skin with a sterile blade; it has few to no adverse effects. Using a scalpel and a delicate touch, the provider simply abrades the surface of the skin using light feathering strokes. It is most often used on patients with rough, dry skin, and /or superficial hyperpigmentation to enhance over all skin tone. It is a safe treatment for patients who are pregnant or nursing who want a deep exfoliation. Many patients are often concerned that the hair will grow back heavier and darker after dermaplaning; this is not the case. Hair will grow back at the same rate and texture as before the treatment within 4 – 6 weeks. Dermaplaning can be done as often as every two weeks, although it is usually done when vellus hair starts to grow back, which is generally in one month's time. This treatment may be recommended to prepare the skin for chemical peels as it allows products to penetrate more readily into the deeper layers. Results may not be seen in a single treatment. Follow-up with maintenance treatments may be recommended.

I, _____, acknowledge and understand that while the goal of this treatment is superficial exfoliation and the removal of vellus hair (peach fuzz), I may receive added improvements such as reduction in the appearance of fine lines & temporary fading of pigmentation. The nature and purpose of the treatment has been explained to me, and any questions I have regarding this procedure have been answered to my satisfaction.

Please read the following information and acknowledge that you understand and accept all provisions by signing below:

___ I acknowledge that proper balancing of the skin will achieve the greatest results prior to obtaining treatments and maintaining skin integrity. It is highly recommended to balance and condition the skin through the use of our homecare products, as the treatments and homecare work together synergistically.

___I realize the goal of this treatment is the removal of superficial facial hair and minimal exfoliation.

___I understand there is potential to receive a paper cut nick from the blade. I understand my skin care provider will treat the area if this should arise.

___I understand that this procedure uses a #14 blade, which is mildly abrasive therefore I will follow the explicit instructions of my skin care professional.

___I understand with any treatment certain risks are involved and that complications or side effects from known or unknown causes could occur. I freely assume these risks.

___If I am prone to herpetic outbreaks, I understand that I may be advised to see a physician about appropriate prescriptions or supplements to control outbreaks prior to treatments.

___I acknowledge my obligation to follow the written and spoken instructions covering my pre and post treatment skin care regimen.

___Any potential risks and complications could result in the need to discontinue the treatment. In this case, an alternative recommendation(s) will be suggested. If the need arises, I authorize my aesthetician to perform such required treatment or procedure. I also agree to immediately inform the aesthetician if I have concerns, or am overly uncomfortable during the treatment, or after I return home.

___I agree to inform my aesthetician when I introduce new medication(s) and/or product(s) during the course of the treatment. I attest that I have had an opportunity to ask questions and have had questions answered to my satisfaction.

I certify that I am over the age of eighteen (18) and that:

___I have not used isotretinoin in the past 12 months

___I do not have a history of radiation to the treated area

___I do not have active herpes simplex or active infection

___I have not waxed in the past week or shaved the treated area for 24 hours

___I have not used Retin A or similar medications for at least 4-5 days or longer

___I WILL protect my skin from direct sun for 3 days post procedure

___I WILL use a broad spectrum sunblock every day and reapply when necessary

___I WILL avoid hot baths/showers, tanning beds, sweating and strenuous exercise for at least 3 days post procedure

___I WILL avoid rubbing, picking and scrubbing my skin post procedure, for I understand it could lead to scarring

___I WILL NOT use retinoids or other exfoliation agents until my skin is healed I have read and will follow to the best of my ability any and all instructions.

___I understand the potential risks and complications, and choose to proceed after careful consideration of the possibility of both known and unknown risks, complications, limitations, and alternatives.

___I will call to inform my skincare specialists of any complications or concerns as soon as they occur. I have read the contents of this consent form carefully and I fully understand it. I have been given the opportunity for discussion pertaining to Dermaplaning treatments and all my questions have been answered to my satisfaction. I have been adequately informed of the risks and benefits of this treatment and wish to proceed with the Dermaplaning treatment.

Client Signature _____ Date _____

Parent/Guardian Signature (if under 18) _____

Aesthetician Signature _____ Date _____