Simple Therapeutics
Fitness & Wellness Center

Informed Consent for Dermaplaning/Microdermabrasion

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

I acknowledge and understand that while the goal of Dermaplaning is superficial exfoliation and the removal of vellus hair (peach fuzz), I may receive added improvements such as reduction in the appearance of fine line and temporary fading of pigmentation.

I understand that Microdermabrasion (Microderm) is a superficial exfoliation designed to prep the skin for optimal absorption of products to be used during this service.

I acknowledge that the Dermaplaning/Microderm treatment is not an exact science and that no specific guarantees can or have been made concerning the expected result. I understand the degree of improvement is variable and occasionally will see no visible improvement and another form of treatment may be required.

I understand that this procedure uses a Dermaplaning/Microderm blade which is mildly abrasive. Therefore I will follow the explicit instructions of my skincare therapist.

I understand that if I add glycolic or other chemical peel solutions onto my Dermaplaning/Microderm treatment that I may achieve greater results, but I will also assume greater risks and have discussed these risks with my skincare therapist.

I have been advised of any alternative treatments which may address my primary concerns.

I understand that during the course of treatments, my skincare specialist may discover other or different conditions that may require additional procedures than what was planned. I understand that my skincare specialist may refer me to an appropriate medical care provider if necessary.

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

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 that the success of my treatment depends on me and I have an obligation to follow the written and spoken instructions concerning pre and post treatment care in order to achieve optimal results.

I understand multiple treatments are recommended to see optimal results. The cost of treatment has been disclosed to me and I understand that payment is due at the time services are rendered.

I am over 18 years of age or have parental consent signed below.

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/Microderm treatments and all my questions have been answered to my satisfaction. I hereby release Simple Therapeutics and any of its employees against any and all liability associated with this procedure. I have been adequately informed of the risks and benefits of this treatment and wish to proceed with the Dermaplaning/Microderm treatment.

Patient's Name (Printed): _____

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____