Simple Therapeutics
Fitness & Wellness Center

IMAGE SKINCARE

Informed Consent for Image Facial Treatment

Patient Name: _____ Date: _____

Skin Condition (Please select all that apply):

☐ Superficial Wrinkles, Fine Lines
☐ Deep Wrinkles, Fine Lines
☐ Acne or Acne Prone
☐ Deep Hyperpigmentation (Sun or Brown Spots)
☐ Severe Photoaging
☐ Rosacea
☐ Dehydration
☐ Acne Scars
☐ Unbalanced

Precautions (Please read carefully)

The treatment you receive is a clinical treatment designed to exfoliate or remove the outer layers of the skin. Your participation in your skincare treatments will determine the outcome. It is important that you strictly adhere to your home care products that your esthetician recommends.

No guarantee is expressed or implied as to the precise results, peeling times, or discomfort.

During the treatment you may experience some temporary stinging or warm flushing. This will fade within a few minutes. During the next few hours you may experience some tightening of the skin which may last for several days. For most patients flaking begins within 48 hours. It is impossible to pre-determine how much peeling will occur. The shedding process usually subsides within 5-7 days.

Depending on the clinical peel performed and your skin quality the following reactions may occur in some patients: 1) Prolonged redness, irritation, and flakiness. 2) Dryness and sensitivity. 3) Severe allergic reactions in rare instances.

Please select all that apply

☐ I am not pregnant.
☐ I am not allergic to aspirin.
☐ I have not used Glycolic Acid for 24 hours.
☐ I have not used Retinol Products for 72 hours.
☐ I have not taken Accutane in the past year.
☐ I agree not to pick, peel, or scratch the skin during the healing phase.
☐ I agree there may be crusting and shedding of the skin.
☐ I agree that I currently do not use Hydrocortisone.
☐ I do not have active cold sores.
☐ I have not received radiation treatments.
☐ I agree to avoid direct sun exposure for 2 weeks.
☐ I agree to notify the esthetician of any concerns.
☐ I agree not to wax for 7 days pre/post treatments.
☐ I agree not to use Retin-A products for 7 days pre/post treatments.

Please list any allergies: _____

Please list any health concerns: _____

Consent: I hereby give my consent and authorization to receive treatment. I release Simple Therapeutics and its employees from any claims, implied or stated, that I have or may have in the future with this treatment, regardless of result. I am stating that the treatment and precautions above have been explained to me in detail and that I fully understand.

Client Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____
(in case of minor)