

# BELIFESTYLE™

LUXURY MEDSPA

## Microdermabrasion Informed Consent Form

Client/Patient consent to treatment:

My signature acknowledges that I have read and agreed to receive the following treatments for series of treatments listed below.

I, \_\_\_\_\_, consent to and authorize Be Medspa, or members of its staff to perform Microdermabrasion exfoliation procedure and related services on me.

Areas to be treated:

\_\_\_\_\_

Number of treatments estimated: \_\_\_\_\_

- a. The nature and purpose of the treatment has been explained to me, and any questions I have regarding this procedure has been explained to my satisfaction. \_\_\_\_\_(initial).
- b. I understand that with any treatment certain risks are involved and that any complications or side effects from known or unknown causes could occur. I freely assume these risks. \_\_\_\_\_(initial)
- c. I have discontinued the use of Retin-A, Retinol, Renova, Differin and any other topical medications for at least one (1) week prior to this procedure. \_\_\_\_\_(initials)
- d. Possible side effects include but are not limited to: Mild redness, extreme redness, bruising, local swelling, stinging, tenderness, dry skin, flaking, lightening or darkening of the skin, infections, pimples, bumpy appearance, and cold sores. Most side effects are temporary and generally fade within seventy-two (72) hours. \_\_\_\_\_(initials)
- e. If prone to cold sores see your physician about a prescription for acyclovair, zovirax, or take supplements of L-Lysine along with beta-carotene and folic acid daily. \_\_\_\_\_(initial)
- f. It is recommended to discontinue all AHA's, Glycolics, Retin-A, Renova, or any exfoliating products for up to seventy-two (72) hours post procedure. Use hydrating, soothing, anti-oxidants, healing, and ice for swelling and inflammation reduction. Also, no sun exposure seventy-two (72) hours an use of an SPF 15 or greater at all times during treatment duration is recommended. \_\_\_\_\_(initial)
- g. Removal of contact lenses is recommended. \_\_\_\_\_(initials).
- h. I agree to adhere to all safety precautions and home skin care program as recommended by my practitioner. \_\_\_\_\_(initials)
- i. I am over 18 years of age or I have parental consent co-signed below. \_\_\_\_\_(initials)
- j. I will call to inform my practitioner of any complications or concerns I may have as soon as they occur \_\_\_\_\_.(initials)

Client/Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Co-Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Medical Director Signature: \_\_\_\_\_ Date: \_\_\_\_\_