



## MEDICAL AESTHETICS

HINGHAM | EASTON | MILTON

## VI PEEL® CONSENT FORM

[WWW.MEDICALAESTHETICSMA.COM](http://WWW.MEDICALAESTHETICSMA.COM)

**HINGHAM**  
38 North Street  
Hingham, MA 02043  
781.556.5676

**EASTON**  
244 Washington Street  
North Easton, MA 02356  
508.219.2113

**MILTON**  
524 Adams Street  
Milton, MA 02186  
617.322.1852

The VI PEEL® contains a synergistic blend of powerful ingredients suitable for all skin types. VI PEEL® will improve the tone, texture and clarity of the skin; reduce age spots, improve hyperpigmentation (including melasma), soften lines and wrinkles; clear acne skin conditions; reduce or eliminate acne scars; and stimulate the production of collagen, for firmer, more youthful skin.

### CONTRAINDICATIONS:

- Patients who are pregnant or who are breast feeding
- Patients who have an aspirin, hydroquinone or phenol allergy
- Patients who have used oral isotretinoin (Accutane) within the past 6 months
- Patients who have active cold sores, warts, open wounds or history of herpes simple
- Patients who are undergoing chemotherapy and or radiation therapy within 6 months
- Patients with a history of an autoimmune (i.e. Lupus) or liver disease disorder as well as any condition that may weaken their immune system.

### AUTHORIZATION (S)

I acknowledge the following points have been discussed with me:

- \_\_\_\_\_  
(Patient Initials) Prior to receiving treatment I have communicated with the Practitioner about any conditions or medications that may contraindicate this procedure.
- \_\_\_\_\_  
(Patient Initials) I understand that there may be some degree of discomfort such as burning, stinging, redness, heat or tightness during and a week after the procedure.
- \_\_\_\_\_  
(Patient Initials) I understand that there is no guarantee of the final results of the peel. Occasionally hyperpigmentation may develop which may persist for a week or months after the peel.
- \_\_\_\_\_  
(Patient Initials) I understand although complications are very rare, sometimes they may occur. In the event of any complications, I will immediately contact the Physician/Clinician who performed the treatment.
- \_\_\_\_\_  
(Patient Initials) I understand if I have any acne condition in the skin, the peel may bring out oils and bacteria from below the surface and can cause an actual breakout.
- \_\_\_\_\_  
(Patient Initials) I understand that maintenance of VI PEEL® treatments are necessary to maintain results as well as the recommended VI DERM® skin care regimen and SPF 50+.
- \_\_\_\_\_  
(Patient Initials) I understand the extended direct sun exposure including tanning beds are strictly prohibited before and after receiving the VI PEEL®.
- \_\_\_\_\_  
(Patient Initials) I understand no activities involving excessive sweating can be done for 72-96 hours (exercise, sauna, hot tub steam room and that overheating may cause me to develop blisters or cause hyperpigmentation to worsen.)
- \_\_\_\_\_  
(Patient Initials) I understand that I must protect my skin with VI DERM® SPF 50+ and avoid sun exposure during the 7 day exfoliation process.
- \_\_\_\_\_  
(Patient Initials) I understand that this is an elective cosmetic procedure.

\_\_\_\_\_ Patient Initials

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\_\_\_\_\_  
(Patient Initials) I understand that no other chemical peels, facial machine brushes or medical device (laser, IPL, etc) treatments may be performed on my skin until my physician/clinician releases me to do so.

\_\_\_\_\_  
(Patient Initials) Photographic documentation will be taken for teaching and before/after purposes. I hereby do not authorize the use of my photographs and understand that all attempts will be made to conceal my identity.

I, \_\_\_\_\_ hereby authorize \_\_\_\_\_ to perform a VI PEEL treatment on me. The nature and purpose of the treatment have been explained to me. I have read and understand this agreement in its entirety. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

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PATIENT SIGNATURE

DATE

TIME

and/or

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RESPONSIBLE RELATIVE OR GUARDIAN

RELATIONSHIP

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PROVIDER'S NAME

PROVIDER'S SIGNATURE

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PEEL TYPE

LOT #

EXP DATE