MEDICAL AESTHETICS

HINGHAM | EASTON | MILTON

VI PEEL® CONSENT FORM

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) 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 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.

PATIENT SIGNATURE DATE TIME

and/or

RESPONSIBLE RELATIVE OR GUARDIAN RELATIONSHIP

PROVIDER'S NAME PROVIDER'S SIGNATURE

PEEL TYPE LOT # EXP DATE