INFORMED CONSENT FOR CHIRALLY CORRECT PEELS

- I _____ understand the purpose of this peeling procedure is to exfoliate the outer surface of my skin. Some of the benefits include lessing of pigmentation, reduction in appearance of fine lines and wrinkles, and control of certain conditions such as acne or occasional breakout.
- I understand that I am to complete a medical history and be complete and truthful about my physical conditions, pregnancy, medications that I may be taking, and my current skin care regimen. I have been candid in revealing any condition that could prohibit this treatment such as I am aware that my lifestyle, when it includes smoking, will effect and diminish the effectiveness and result of the peel treatment. Initial _____
- I understand there is a possibility of side effects or complications can occur:

  - Discomfort
  - Redness and Swelling
  - Hypo-pigmentation
  - Itching or irritation
  - Skin peeling or flaking up to 14 days after the procedure
  - Infection
  - Scarring
  - Hyper-pigmentation
  - Acne or milia breakout
  - Initial _____

- I understand that although complications are very rare on occasion, they may occur requiring prompt treatment. In the event of any complication, I will immediately contact the doctor/technician who performed the treatment. Initial _____
- I agree to refrain from excessive sun exposure or the use of a tanning bed while I am undergoing treatment and during the 14 days following the end of the treatment. Initial _____
- I have not had any other peel treatment of any kind within 14 days of treatment. I understand I cannot have another treatment within 14 days of this treatment, whether the treatment is performed at this location or any other location. Initial _____
- If I have any questions regarding this procedure, I agree to call Karen Hawkins at PH: 205 764-1293 to discuss any concerns. Initial _____
- I understand that to achieve maximum results the recommended home care routine must be followed. I understand that if I modify the routine or use products not recommended by the skin care professional the results could be altered or inhibitive. I also understand that it may take several treatments to obtain the desired results. Initial _____
- I understand that direct sun exposure is prohibited while I am undergoing treatment and that the use of sun block protection with a minimum of SPF 15 is mandatory. Initial _____
- I understand that the following conditions preclude me from having this treatment at this time and verify that none of these conditions apply to me at this time. Initial _____

  ____ Allergic to aspirin or any salicylic sensitivity (salicylic acid).
  ____ Broken skin
  ____ Inflammation
  ____ Recent peels within eight weeks
  ____ Herpes virus (cold sores)
  ____ Use of Accutane within the past 12 months
  ____ Use of glycolic acid products, Retin-A or Renova™ in the last 4 weeks

INFORMED CONSENT

I have read and understand this agreement and all of my questions have been answered. I agree to these terms and I want to proceed with this procedure as indicated.

Signed _____ Date _____

Practitioner _____ Date _____