

NORTH COUNTRY ENT & MED SPA

INFORMED CONSENT FOR SKIN TREATMENT

I, _____, give permission to my skin care professional/esthetician,
_____, to perform the skin treatment(s): (circle treatment(s))

Lactic / Alpha/Beta / Jessner's / DermaFrost / Salicylic / Mandeli-Clear / Microdermabrasion
Tattoo Removal / Infa-Slim / Enzyme Facial / Spray Tan / Micro-Needling / Bacial
FuturaFace LED Light Treatment / Teeth Whitening / Galvanic / Radio Frequency
_____ / _____ / _____ / _____ / _____

PLEASE INITIAL EACH PARAGRAPH

1. ____ I agree to complete a Confidential Skin Health Questionnaire. I agree to complete and be truthful about my physical conditions, pregnancy, medications that I may be taking, and my current skin care regimen. I am also aware that my lifestyle, which if it includes smoking, outdoor exposure, tanning beds, excessive alcohol consumption and/or recreational use of controlled substances, will effect and diminish the effectiveness and result of the treatment.
2. ____ I have disclosed to my skin care professional/esthetician any surgical procedures, laser treatments or facial procedures that I have had or intend on having in the future.
3. ____ I am not presently pregnant or lactating.
4. ____ I have not had any recent chemotherapy or radiation treatments.
5. ____ I have not recently waxed or used a depilatory (such as Nair) on the area being treated today.
6. ____ I do not have a history of keloid scarring, diabetes, any autoimmune disease, active herpes blisters or cold sores.
7. ____ 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.
8. ____ 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.
9. ____ I understand that sun exposure is prohibited while I am undergoing treatment and that the use of a broad-spectrum sunscreen is mandatory. We recommend Circadia, Skinceuticles or Elta MD Sunscreen.
10. ____ I understand the purpose of a peeling procedure is to exfoliate the outer surface of my skin. Some of the benefits include lessening of pigmentation, reduction in appearance of fine lines and wrinkles, and control of certain conditions such as acne or occasional breakout.
11. ____ I understand that the following conditions may preclude me from having this treatment at this time and verify that none of these conditions apply to me at this time.
 - ____ Allergic to aspirin or any salicylic sensitivity (DermaFrost contains salicylic acid).
 - ____ Broken skin on areas to be treated
 - ____ Sunburn or windburn skin
 - ____ Visible inflammatory or inflammatory lesions
 - ____ Recent peels within eight weeks
 - ____ Herpes virus (cold sores) on mouth
 - ____ Use of Accutane® within the past 12 months
 - ____ Use of Glycolic acid products
 - ____ Use of Retin-A®, Renova®, retinoids (Vitamin A) in the last 4 weeks

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12. ____ My expectations are realistic and I understand that the results are not guaranteed and that for maximum results, more than one application may be necessary. The rate of improvement depends on my skin type, condition, my age, degree of sun damage, and/or pigmentation levels.
13. ____ I understand the cost of treatment and the fee structure has been explained to me.
14. ____ I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complication, I will immediately contact the skin care professional/esthetician who performed the treatment.
15. ____ I understand of the possibility of peeling, flaking, hyperpigmentation and excessive dryness. I agree to use the products specifically recommended by my skin care professional/esthetician including a sunscreen.
16. ____ I understand that every precaution will be taken to minimize or eliminate negative reactions such as blisters, redness, or irritation.
17. ____ I understand that my skin care professional/esthetician will recommend home care products to work in tandem with the in-clinic treatment. I am willing to follow recommendations by my skin care professional/esthetician for home care.
18. ____ I consent to the taking of photographs to monitor treatment effect and results if desired by my skin care professional/esthetician.
19. ____ I consent to being registered with the TouchMD Service Online System.
20. ____ I accept the Terms & Conditions of TouchMD – a printed copy of which is available upon request and an electronic form is available on the TouchMD website.

INFORMED CONSENT

In the event of any questions or concerns, I will consult with my skin care professional/esthetician immediately. I understand the potential risks and complications and I have chosen to proceed with the treatment(s) after careful consideration of both known and unknown risks, complications, and limitations. I will hold the skin care professional/esthetician and staff harmless from any liability that may result from this treatment(s) or any future treatments and thereafter. I have been instructed that it is my responsibility to communicate, and be completely truthful and honest with the skin care professional/esthetician.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

Client Signature _____ Date _____

Client Name Printed _____

Skin Care Professional/Esthetician Signature _____ Date _____

Skin Care Professional/Esthetician Name Printed _____