

**MICRODERMABRASION INFORMED CONSENT FORM**

\_\_\_\_\_

**Last Name**

\_\_\_\_\_

**First Name**

**This consent form is designed to verify that you have been satisfactorily informed and educated in respect to your skin care treatment, as well as its aftercare, so that you may make an educated decision as to whether to have this procedure performed. Please read and initial each paragraph below and freely ask us any questions you may have.**

**GENERAL INFORMATION:**

\_\_\_\_\_ Prior to receiving this treatment, I have been candid in revealing any condition that may have a bearing on this procedure, such as pregnancy, recent facial peels or surgery, allergies, Lupus, Diabetes with poor wound healing, active rosacea, psoriasis, tendencies to develop cold sores and fever blisters, use of Retin-A within 1 week, use of Accutane within 6 months or diagnosed keloid scarring.

\_\_\_\_\_ I understand that this non-chemical, non-invasive treatment using oxidized crystals to exfoliate or remove the outer layer of dead skin cells from the skin's surface and that it may take multiple treatments to achieve the desired effects.

\_\_\_\_\_ I understand this is a process and therefore not an exact science and that all clients have different experiences and outcomes due to their unique skin conditions.

\_\_\_\_\_ I understand there may be some degree of discomfort such as stinging and/or pin-prick sensation.

\_\_\_\_\_ I understand there are no guarantees as to the results of this treatment due to many variables, such as: age, condition of skin, sun damage, smoking, drinking, climate, etc.

\_\_\_\_\_ I agree to refrain from tanning in tanning beds or outdoors during the 14 days following the treatment.

\_\_\_\_\_ I understand that the daily use of sunscreen protection with an SPF 30 is mandatory.

**RISKS/SIDE EFFECTS**

\_\_\_\_\_ I understand that this procedure may have side effects. The most common side effects associated with this procedure are: erythema (redness) and edema (swelling) of the treated area that can occur and usually subsides within a few hours but can last up to 5 days or longer; irritation, itching, and/or pin-point bleeding; pigment changes such as hyper-pigmentation and hypo-pigmentation of the skin in the treated areas (mostly these pigment changes are transient, lasting up to six months, but in rare cases it can be permanent, and these pigment changes may occur despite appropriate protection from the sun); cold sores; allergic reactions; and scarring. I acknowledge that following all post procedure instructions will help avoid such side effects.

\_\_\_\_\_

Tech Initials

\_\_\_\_\_

Date



ALL OVER BEAUTIFUL

MED SPA

\_\_\_\_\_ I understand that although complications are rare, sometimes they may occur and that attention may be necessary. In the event of any complication, I will immediately contact the center.

**AUTHORIZATION AND WAIVER**

\_\_\_\_\_ I hereby authorize AOB Med Spa, its employees, and agents to perform the skin care procedure on me. I fully understand that this procedure has limited applications. I am aware that the practice of esthetics is not an exact science and I acknowledge that my aesthetician cannot guarantee quality and/or results or freedom from complications. I acknowledge that I have had the opportunity to ask questions, and that I fully understand the procedure.

\_\_\_\_\_ I understand and acknowledge that there are risks involved with the skin care procedure, including but not limited to those side effects listed above. I have had the opportunity to ask questions regarding these risks and other possible complications. I understand that any false or misleading information I have given may lead to undesired results and complications and hereby release and hold harmless AOB Med Spa from any and all liability if such results or complications occur. I further understand that my failure to follow post care instructions may also lead to undesired results, complications or effects and hereby release and hold harmless AOB Med Spa from liability if such results or complications occur.

**\_\_\_\_\_ Any payment made on AOB Med Spa treatments is non-refundable. Any unused treatments will be available as an in-house credit on your account, and can be used to purchase treatments or products.**

**I certify that I have read and fully understand the above paragraphs, that I have had sufficient opportunity for discussion and to ask questions, and that I hereby consent to the procedure described above.**

\_\_\_\_\_  
Client Signature (or Responsible Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Tech Initials

\_\_\_\_\_  
Date