

**AUTHORIZATION AND CONSENT FOR
CHEMICAL PEEL**

**PLEASE READ THIS AUTHORIZATION CAREFULLY AND ACKNOWLEDGE
YOUR UNDERSTANDING BY SIGNING YOUR NAME IN THE SPACE BELOW.**

You have the right to be informed about the procedure to be used, indicating risks and benefits, so that you may make the decision whether or not to undergo the procedure. This authorization and consent form is an effort to make you better informed. To that end you are encouraged to ask any questions you may have. You are also encouraged to conduct your own research or consult with your own health care provider if you have additional questions.

Procedure. Chemical peels works by loosening and/or removing skin cells from the skin's epidermal layer. I understand that it may take multiple treatments to achieve the desired effects.

Possible Side Effects. I understand that this procedure(s) may cause side effects. The side effects listed here are merely examples and are not intended to be an exhaustive list. Every person is different, and there is no guarantee that more severe side effects will not occur. Of the observed side effects, the most common are listed. There may be **temporary redness** and **skin tightness, mild discomfort during the procedure, scabbing and peeling** of skin in treatment and surrounding area, **prolonged skin sensitivity** to wind and sun, and areas of **persistent increased or decreased pigmentation**. Any potential risk or complication could result in the need to discontinue the treatment. I understand that very rarely **permanent damage** can occur. I agree to notify the Esthetician if I am overly uncomfortable during or following the procedure(s).

Patient Questionnaire. By my signature below, I certify that the answers given herein are true and complete to the best of my knowledge.

Are you pregnant or trying to become pregnant? Yes No

Are you nursing? Yes No

Are you currently taking any antibiotics? Yes No

If so, please list and state the date you started taking the medication: _____

Do you have any allergies, including an allergy to milk, aspirin, seafood, or apples? Yes No

If so, please list: _____

Have you taken accutane within the past two (2) months? Yes No

Are you taking any topical acne medicine, including Tazerac, Differin, Retin A, glycolic treatments, prednisone, or corticosteriods (i.e. elocon, kenalog)? Yes No

If so, please list: _____

Do you have diabetes? Yes No

Have you been tanning within the past 24 hours? Yes No

Do you have any skin sensitivities? Yes No

If so, please list: _____

Authorization. I hereby authorize Skinology LLC, its employees, and agents to perform the chemical peel procedure(s) on me. I fully understand that this procedure(s) has limited applications. I am aware that the practice of esthetics, like medicine and surgery, is not an exact science, and I acknowledge that reputable practitioners cannot properly 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 chemical peel procedure(s).

Waiver. I understand and acknowledge that there are risks involved with the chemical peel procedure(s) 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 waive Skinology LLC's liability if such results or complications occur. I further understand that my failure to follow post-procedure instructions may also lead to undesired results, complications or effects and hereby waive Skinology LLC's liability if such results or complications occur.

I agree to inform the Esthetician should I introduce any new medication(s) or product(s) during the course of treatment.

In consideration for Skinology LLC performing this procedure(s), I agree that I will assume the risk and full responsibility for any and all injuries, losses, or damages, which might occur to me while I am undergoing this procedure(s) or side effects I may experience after the procedure(s) is performed. To the maximum extent allowed by law, I agree to waive and release any and all present and future claims, suits or related causes of action against Skinology LLC, its owners, officers, employees, or agents for negligence, injury, loss, death, costs or other injuries or damages to me as a result of this procedure(s).

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(s) described above.

Client Signature

Printed Name

Date

Signature of Parent/Guardian (if under 18)

Printed Name

Date

Witness Signature

Printed Name

Date

Skinology
Skin. Science. Simplified.