Chemical Peel Consent Form

[COMPANYLOGO]

FULL DISCLOSURE

Prior to receiving treatment, I have completed and signed the Patient Profile given to me by my physician/ skincare professional. I have been truthful in disclosing information that may have bearing on this procedure including, without limitation-

- ☐ I have not taken Accutane in the last six months
- ☐ I am not pregnant/breastfeeding
- ☐ I have declared all known allergies including Aspirin.
- ☐ I do not have an autoimmune illness
- ☐ I have not had a cold sore in the last 7 days
- ☐ I am not currently receiving cancer treatment
- ☐ I have disclosed all prescription and nonprescription products that I am using

CONDITIONS OF TREATMENT

- ☐ I agree to follow all post-procedure protocols recommended by my physician/ skincare professional
- ☐ I agree to use the recommended sun protection product (SPF 30 or higher) on the treated area for a minimum of 14 days post treatment. I understand AlumierMD recommends using a sunscreen of SPF 40 or higher.
- ☐ I agree to refrain from the following activities for 7 days post treatment and accept full responsibility for any adverse event that occurs as a result of my participation in these activities:

Activities to refrain from for 7 days post treatment

- ☐ Waxing, threading, and use of all other depilatories
- ☐ Neurotoxin injections (e.g., Botox, Dysport)
- ☐ Use of retinoids
- ☐ Use of mechanical exfoliants
- ☐ Use of topical AHA/BHA and all other exfoliant topical skincare products
- ☐ Use of sunless tanning products
- ☐ Acne topical treatments

- ☐ I agree to refrain from the following activities for 14 days post treatment and accept full responsibility for any adverse event that occurs as a result of my participation in these activities:

Activities to refrain from for 14 days post treatment

- ☐ Sun or tanning bed exposure
- ☐ Microdermabrasion
- ☐ Laser hair removal
- ☐ Dermal filler injections

I understand and accept that the following may occur post treatment:

- ☐ Likely: Temporary sensation of heat and itchiness immediately following treatment
- ☐ Possible: Contact dermatitis, inflammation (redness), oedema (swelling), skin irritation (itchiness)
- ☐ Unlikely: Hyperpigmentation/ hypopigmentation: I agree to follow the recommended post-procedure instructions to minimize the chance of this occurring.

LIMITATIONS OF CHEMICAL PEELING TREATMENT

- [ ] I understand there are no guarantees as to the results of this treatment due to many variables including age, skin condition, sun damage, smoking habits and climate.
- [ ] I understand that this treatment is cosmetic and that no medical claims are expressed or implied by AlumierMD or by the skincare professional.
- [ ] I understand that to achieve maximum results, I may require several treatments.
- [ ] I understand that there are ultimately no guarantees as to the results of this treatment

POSSIBLE ADVERSE EVENTS

- [ ] I understand that although adverse events are rare, they do occur, and prompt treatment is necessary.
- [ ] In the event of any adverse event outlined below I will immediately discontinue use of all professional treatments and contact the physician/skincare professional who performed my treatment.

CONSENT TO TREATMENT

- [ ] I hereby certify that all the information that I have provided has been accurate and truthful.
- [ ] I acknowledge reading all the information contained herein regarding the possible adverse events associated with the treatment, that such adverse events have been properly explained and that I consent to such treatment with full knowledge thereof.
- [ ] I acknowledge that I have been able to ask any questions regarding my concerns around this treatment.
- [ ] I hereby agree to treatment in alignment with all considerations outlined in this consent form.

TX1

DATE: ____________________ dd / mm / yyyy INITIAL: ____________________

TX 2

DATE: ____________________ dd / mm / yyyy INITIAL: ____________________

TX 3

DATE: ____________________ dd / mm / yyyy INITIAL: ____________________

TX 4

DATE: ____________________ dd / mm / yyyy INITIAL: ____________________

TX 5

DATE: ____________________ dd / mm / yyyy INITIAL: ____________________

TX 6

DATE: ____________________ dd / mm / yyyy INITIAL: ____________________

TX 7

DATE: ____________________ dd / mm / yyyy INITIAL: ____________________

TX 8

DATE: ____________________ dd / mm / yyyy INITIAL: ____________________

SIGNATURE PATIENT *

DATED: ______________________________ dd / mm / yyyy

SIGNATURE PRACTITIONER

DATED: ______________________________ dd / mm / yyyy