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Vibradermabrasion, Microdermabrasion, JetPeel and Chemical Peels Consent

My signature below constitutes acknowledgement that:

I _____ consent to and authorize members of the Body Focus Laser & Longevity Center to perform one of the following procedures: Vibradermabrasion, Microdermabrasion, JetPeel and/or Acid or Chemical Peels and related services on me.

Procedure elected is:_____ Body Area:_____

Those procedures involve the use of a different modalities to remove the top layers of the skin. This treatment should be used as part of a complete skin care program to maximize the overall benefits. A skin care program has been recommendation to me as part of this treatment.
_____ Initials

The nature and purpose of the treatment has been explained to me, and any questions I have regarding treatment have been answered to my satisfaction.
_____ Initials

I understand that the treatment may involve the risk of complications or injury from both known and unknown causes and I freely assume these risks. Possible side effects of the treatment area can include mild redness of the skin, irritation, local swelling, mild discomfort or tenderness, pimple-like bumps, dry skin, lightening of the skin, infection, scarring, peeling, and activation of cold sores.
_____ Initials

I certify that I have read this entire consent and that I understand and agree to the information provided in this form. I certify that I an a competent adult of at least 18 years of age, or that, if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian having legal custody will also be required before treatment. This consent freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns.
_____ Initials

I agree to adhere to all safety precautions and regulations during the skin treatment.

I have received and understand the post care recommendations as follows: no sun exposure for 48 hours, use gentle cleanser only, acid washer (if desired) may be resumed 48 hours after treatment.
_____ Initials

Patient Signature: _____ Date: _____/_____/____

Parent/Legal Guardian: _____ Date: _____/____/_____