FACIAL PLASTIC
SURGERY CENTER
*A division of Otolaryngology Associates, PC*

# MICRODERMABRASION CONSENT FORM

Patient_____ Date_____

1. 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, tendencies to cold sores and fever blisters, use of Retin-A, Accutane or Hormones.

2. I understand there may be some degree of minor discomfort, i.e., scratchiness, itchiness.

3. I understand there are no guarantees to this procedure.

4. I understand that to achieve maximum results, I will need several ongoing treatments and use a daily product over a period of time.

5. I understand that the possibility of irritation and redness exists and that I should notify my skin care professional when irritation persists.

6. I will follow the home care program specifically designed for me without changing or adding any products without consulting with my skin care professional.

7. I have read the enclosed consultation and understand the contents.

I agree to all of the above to have this treatment performed on me and will follow all prescribed directions regarding post peel care.

Patient_____ Date_____
*(or legal guardian)*

Witness_____ Date_____