Evergreen LASER
Laser Hair Removal & Med Spa

Chemical Exfoliation/Dermaplaning Consent Form

Patient Name:_____ Date:_____
(First) (Last)

This form provides detailed information regarding Chemical Exfoliation/Dermaplaning (hereinafter the "Treatment"). Please read this form thoroughly and make sure all your questions are answered before deciding to undergo treatment. After reading this document, **please initial each section**, and date the appropriate areas.

x _____ **Risks:** I have been informed about the treatment, procedure, indications, expected results, and possible side ects. I understand that I may experience swelling, redness, tightness, and scratching of the skin; however, these symptoms will resolve.

x _____ Although results are usually dramatic, I have been informed that the practice of medicine is not an exact science and that no guarantees can be made or have been made concerning the expected results in my case.

x _____ I am undergoing treatment of my own free will. I agree that this procedure is being performed for cosmetic reasons. I understand that while every precaution will be taken to prevent complications and that complication from this procedure are rare, they can sometimes occur.

x _ _ _____ **Pre-Care and After-Care: I understand pre-care and after-care are entirely in my control. Failure** to follow the provided pre-care and after-care guidelines will increase the chance of complications and adverse side effects and decrease the effectiveness of the Treatment. I acknowledge that I have been (or will be given) detailed oral and printed care instructions. If I have any questions about pre-care or after-care, I can contact the office. I agree to follow all of the pre-care and after-care instructions.

x _____ I accept responsibility for any complications that may occur and thereby absolve Evergreen Laser Laser Hair Removal & Med Spa and any associated person.

x _____ I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

x _____ I have not taken Accutane in the last six months, had blood-thinning medications, waxed, used Retin-A, or any prescribed acne medications in the previous 48 hours.

_____ _____
PRINTED NAME OF PATIENT (FIRST, LAST) PATIENT SIGNATURE

_____
DATE