



Medical Microdermabrasion

Consent Form

I consent to the treatment known as a Medical Microdermabrasion. The treatment has been explained to me, and I have had the opportunity to ask questions. I understand that the procedure may cause swelling or puffiness of my face or (body site treated) that may be uncomfortable. The following may be experienced: stinging, itching, burning, mild pain, tightness, and scabbing of the superficial layers of the skin. These sensations will gradually diminish over the course of a week as the skin returns to its normal appearance. However, some patients may react differently. For example, in rare cases the skin may turn very red, swell, and later scab and crust. The skin may be uncomfortable and look like a very bad sunburn.

I understand that there is a small risk of developing a temporary or permanent pigment (color) change in the skin. There is a small incidence of the reactivation of cold sores (herpes infections) in patients with a prior history of herpes, this can be treated or pretreated with cold sore medication. There also is a small incidence of a flare of acne-like lesions after the peel. There is a rare incidence of scarring and infection. I have been given a copy of the post-peel instructions and have reviewed them.

I acknowledge the importance of documenting my care with before and after photos and give permission for Roots of Nature Aesthetic and Wellness to do so.

I understand that my photographs may be used for educational, training and/or marketing purposes without gratuity and that reasonable attempts to conceal my identity will be made. No listing of my name will be shown. Cropping of the picture will be performed to show primarily the affected areas.

Signature: _____

Date (dd/mm/yyyy): _____