



# INFORMED CONSENT FOR IMAGE TREATMENTS

## PATIENT/CLIENT INFORMATION

DATE \_\_\_\_\_  
NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY/STATE/ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_  
WORK PHONE \_\_\_\_\_  
CELL \_\_\_\_\_  
EMAIL \_\_\_\_\_  
FAX \_\_\_\_\_

## TREATMENT (Please initial by each statement)

\_\_\_\_\_ The treatment was explained to me in detail.  
\_\_\_\_\_ The benefits of what I can realistically expect to see from my Clinical Peel have been fully explained to me.

## TREATMENT (Please select one)

\_\_\_\_\_ O2 LIFT  
\_\_\_\_\_ ORMEDIC LIFT™ PEEL  
\_\_\_\_\_ THE SIGNATURE FACELIFT® PEEL  
\_\_\_\_\_ LIGHTENING LIFT® PEEL  
\_\_\_\_\_ WRINKLE LIFT® PEEL

\_\_\_\_\_ ACNE LIFT® PEEL  
\_\_\_\_\_ BETA LIFT™ PEEL  
\_\_\_\_\_ PERFECTION LIFT™ PEEL  
\_\_\_\_\_ TCA ORANGE PEEL®  
\_\_\_\_\_ IMAGE FACIAL

## SKIN CONDITION (Please select all that apply)

\_\_\_\_\_ SUPERFICIAL WRINKLES, FINE LINES  
\_\_\_\_\_ DEEP WRINKLES, FINE LINES  
\_\_\_\_\_ ACNE OR ACNE PRONE  
\_\_\_\_\_ DEEP HYPERPIGMENTATION (SUN OR BROWN SPOTS)  
\_\_\_\_\_ SEVERE PHOTOAGING  
\_\_\_\_\_ ROSACEA  
\_\_\_\_\_ DEHYDRATION  
\_\_\_\_\_ ACNE SCARS  
\_\_\_\_\_ UNBALANCED

## PRECAUTIONS (Please Read Carefully)

**The treatment** you will receive is a clinical treatment designed to exfoliate or remove the outer layers of the skin.  
**Your participation** in your skincare treatments will determine the outcome. It is important that you strictly adhere to your home care products that your aesthetician has recommended.  
**No guarantee** is expressed or implied as to the precise results, peeling times or discomfort.  
**During the treatment**, you may experience some temporary stinging or warm flushing. This will fade within a few minutes. During the next few hours, you may experience some tightening of the skin, which may last for several days.  
**For most patients**, flaking begins within 48 hours. It is impossible to pre-determine how much peeling will occur. The shedding process usually subsides within 5-7 days.  
**Depending on the clinical peel** performed and your skin quality, the following reactions may occur in some patients:  
1) Prolonged redness, irritation and flakiness 2) Dryness and sensitivity 3) Severe allergic reactions in rare instances

## PLEASE INITIAL (Please Read Carefully)

\_\_\_\_\_ I AM NOT PREGNANT.\*\*  
\_\_\_\_\_ I AM NOT ALLERGIC TO ASPIRIN.  
\_\_\_\_\_ I HAVE NOT USED GLYCOLIC ACID FOR 24 HRS.  
\_\_\_\_\_ I HAVE NOT USED RETINOL PRODUCTS FOR 72 HRS.  
\_\_\_\_\_ I HAVE NOT TAKEN ACCUTANE IN THE PAST YEAR.  
\_\_\_\_\_ I AGREE NOT TO PICK, PEEL, OR SCRATCH THE SKIN DURING HEALING PHASE.  
\_\_\_\_\_ I AGREE THERE MAY BE CRUSTING AND SHEDDING OF SKIN.  
\_\_\_\_\_ A PRIOR PATCH TEST HAS BEEN GIVEN TO ME TO RULE OUT ANY ALLERGIC TENDENCIES.  
\_\_\_\_\_ I AGREE THAT I CURRENTLY DO NOT USE HYDROCORTISONE.

\_\_\_\_\_ I DO NOT HAVE ACTIVE COLD SORES.  
\_\_\_\_\_ I HAVE NOT RECEIVED RADIATION TREATMENTS.  
\_\_\_\_\_ I AGREE IT IS MANDATORY TO USE IMAGE POST PEEL KIT.  
\_\_\_\_\_ I AGREE TO AVOID DIRECT SUN EXPOSURE FOR 2 WEEKS.  
\_\_\_\_\_ I AGREE TO NOTIFY DR/AESTHETICIAN OF ANY CONCERNS.  
\_\_\_\_\_ I AGREE TO APPLY IMAGE PREVENTION+.  
\_\_\_\_\_ I AGREE NOT TO WAX FOR 7 DAYS PRE/POST-TREATMENTS.  
\_\_\_\_\_ I AGREE TO FOLLOW UP WITH SCHEDULED APPOINTMENT.  
\_\_\_\_\_ I AGREE NOT TO USE RETIN-A PRODUCTS 7 DAYS PRE/POST-TREATMENTS.  
\_\_\_\_\_ I AM UNDER THE SUPERVISION OF A PHYSICIAN AND HAVE DISCUSSED THE TREATMENT PLAN WITH MY PHYSICIAN.

\*\* EXCEPTION ORMEDIC LIFT AND SIGNATURE LIFT SAFE FOR PREGNANT WOMEN.

## CONSENT (Please sign)

I hereby give my consent and authorization voluntarily and release \_\_\_\_\_ (Name of business) from any claims, implied or stated that, I have or may have in the future with this treatment, regardless of result. I am stating that the treatment and precautions above have been explained to me in detail and that I fully understand.

CLIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_