



**INFORMED CONSENT
FOR MICRODERMABRASION TREATMENT**

I, _____, consent to and authorize the certified staff of **BIOAesthetics Skin Enhancement & Rejuvenation, LLC** to perform professional skin exfoliation (Microdermabrasion).

Area(s) to be treated:

Number of treatments estimated: 6

- For Microdermabrasion exfoliation treatments I will discontinue all AHA's, Glycolics, Retin-A, Renova, Retinol A, or any exfoliating products for up to 72 hours post-procedure. I understand that I must use hydrating and soothing antioxidants for healing, and ice for swelling and inflammation reduction. Also, I understand there should be no sun exposure for 72 hours and the use of an SPF 30 at all times during treatment duration is advised. ____ **Initial**
- I will avoid collagen injections for up to 10-14 days before and to avoid Botox injections for up to 7 days before any Microdermabrasion treatment and agree to these restrictions. ____ **Initial**
- If I am prone to Herpetic outbreaks, I will see my physician about a prescription for Acyclovir or Zovirax. ____ **Initial**
- I understand that with any treatment certain risks are involved and that any complications or side effects from known or unknown causes could occur. I freely assume these risks. ____ **Initial**
- Possible side effects may include, but are not limited to: Mild redness, extreme redness, bruising, local swelling, stinging, tenderness, dry skin, flaking, lightening or darkening of the skin, infections, pimples, bumpy appearance, and cold sores. Most side effects are temporary and generally subside within 72 hours. ____ **Initial**
- I agree to adhere to all safety precautions and home skin care programs as recommended by my Aesthetician. ____ **Initial**
- The nature and purpose of the treatment has been explained to me, and any questions I have regarding this procedure have been explained to my satisfaction. ____ **Initial**
- I am over 18 years of age or I have parental consent co-signed below. ____ **Initial**
- I will call to inform my Aesthetician of any complications or concerns I may have as soon as they occur. ____ **Initial**

My signature acknowledges that I have read the above and agree to the terms:

CLIENT/PATIENT SIGNATURE DATE

PARENTAL SIGNATURE DATE

WITNESS DATE