DERMAFILE™

Informed Consent for Dermafile™ Exfoliation Treatment(s)

I,_____

Authorize_____

Business Name_____

To perform the Dermafile™ exfoliation treatment(s)

Initial

_____ I acknowledge that no guarantee has been made about the results of the procedure. Although it is impossible to list every potential risk and complication, I have been informed of some possible benefits, risks and complications which may include, but are not limited to, the following:

*Provides a smoother appearance of the skin.
*Improves the appearance of fine lines an wrinkles
*helps to even the coloring and lighten the pigmentation of the skin
*Supports the natural collagen syntheses in the skin
*Helps to build collagen and thicken the dermis.
*firms and tightens the skin
*reduces scaring and acne lesions
may cause:
*redness dehydration peeling and swelling of the face
*skin to feel wind burned or sensitive for a few days.
*mild scabbing on areas that have been worked on aggressively.

_____ I attest that I have had an opportunity to ask questions and have questions answered to my satisfaction.

_____ I am over the age of eighteen, and have discussed any skin conditions or diseases, infection or cold sores with my esthetician or physician and understand that this procedure could result in a flare-up of these conditions.

_____ I give my permission for photographs to be taken to record my progress.

_____ These photos may be used for teaching or advertising purposes. I may request that my eyes be covered to conceal my identity.

_____ I agree to follow post treatment instructions.

Date:_____patient signiture_____

Date:_____witness signature_____