DentalBees
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CosMedix Peel Consent Form

Patient's name: _____

I consent that:

Initial	Treatment
	I have completed the medical form accurately.
	I currently have no cold sores and if I have the Herpes Virus, I will prep on an antiviral.
	I am not currently pregnant or breast feeding.
	I have no allergies that will contraindicate me to having the treatment. Eg Salicylic acid.
	I do not have open lesions, eczema or inflamed skin on the area to be treated.
	I understand there are no guaranteed results from this treatment. Many variables exist such as; age, sun damage, ongoing sun exposure, smoking, excessive alcohol intake, climate, diet and water intake, skin thickness and sensitivity.
	I understand the purpose of this peeling procedure is exfoliate the outer surface of my skin, which may or may not result in skin peeling or flaking, as each case is individual.
	I will not scratch, pick, pull at or abrade the treated skin.
	I understand that direct sun exposure and use of tanning booths are prohibited during this treatment time and that a minimum SPF 15 physical sun protection (no fragrance) must be applied daily.
	I understand that to achieve maximum results and to avoid complications, the recommended home care routine must be followed. I understand that if I alter the routine or use products not recommended by the skin care professional the results could be altered or inhibitive.
	I understand that it may take several treatments to obtain the desired results.
	I understand that the following side effects can occur; 1. Discomfort 2. Redness and swelling 3. Itching or irritation 4. Skin peeling or flaking up to 14 days after the procedure 5. Hyperpigmentation 6. Acne Breakouts
	I understand the following complications can occur, although are very rare. I also understand that if they are to occur, I accept full responsibility for any medical care that may become necessary. I will immediately contact the Doctor, Nurse or Skin Specialist performing the treatment. 1. Hypopigmentation 2. Infection 3. Scarring
	I understand the goals of the treatment as well as the limitations and possible complications.
	My Skin Specialist has provided the information and has answered all my questions concerning this procedure. I clearly understand.

I understand the cost of the fee structure has been explained to me.
Cost of Treatment: £_____ Series of Cost: £

I have read and understand this agreement and all of my questions have been answered. I agree to these terms and I want to proceed with this procedure as indicated.

Patient Signature: _____ **Date:** _____

Address: 1 St Andrew St,
Castle Douglas,
DG7 1DE
Phone: 01556 503348
Email: info@dentalbees.com

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CosMedix Post Peel Treatment Instructions

In order to achieve the best results from your peel treatment, we ask that you read and understand the following instructions. Your Skin Specialist / Physician will review the relevant post treatment protocol with you.

1. Your recovery time will be influenced by the type of peel treatment you have received and your individual skin's response. Your Skin Specialist will have discussed with you the individual time frame you should expect.

2. I agree to **STOP, DICONTINUE or NOT HAVE ANY OF THE FOLLOWING TREATMENTS:**

For 24hrs post treatment
Exercise (avoid getting overheated) Bathing or Showering
For 5 to 10 Days post treatment
Exfoliating products (scrubs, AHA's, BHA's Vitamin A) Products not recommended by my Skin Specialist Home Needling Anti –wrinkle injections Prescription topical Retin A Sun exposure to area treated
2 weeks post treatment
Waxing, bleaching or hair dying any areas to be treated Depilatory use in any treated area Electrolysis on any treatment area IPL/Laser Hair removal treatments IPL/Laser Skin Rejuvenation (Only prior to very superficial peels) Facial Treatments of any kind including any AHA , BHA, Vitamin A or TCA treatments Microdermabrasion / Epidermal levelling Hair colour or treatments of any type Dermal Fillers
4 weeks post treatment
IPL/Laser Skin Rejuvenation 9Only prior to Superficial to Medium Depth peels AHA ,BHA, Vitamin A or TCA Superficial to Deep Peels Needling (Standard in clinic or Medical) Fractional Ablative Laser Resurfacing / Full Ablative Laser Resurfacing Facelift Surgery.

3. I also agree to:

a. NOT TO PICK AT SKIN
b. Increase water intake to include "at least" 8 glasses
c. Wear Physical Sun Protection and reapply every 2 hours
d. Not use wash cloths, or any other type of cloth on skin, instead, apply cleanser to clean hands and foam for application.

Additional Instructions:

_____

_____

I understand and agree to comply with the above instructions. I also agree to contact the clinic with any further questions.

Client / Patient Signature _____ **Date** _____

Specialist _____

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Castle Douglas,
DG7 1DE
Phone: 01556 503348
Email: info@dentalbees.com

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Patient Consent

Client / Patient Signature: _____
Skin Specialist: _____
Date: _____
Treatment 1: _____

Please confirm that your profile, including your medical history has not changed since your last treatment.

Client / Patient Signature: _____
Skin Specialist: _____
Date: _____
Treatment 2: _____

Please confirm that your profile, including your medical history has not changed since your last treatment.

Client / Patient Signature: _____
Skin Specialist: _____
Date: _____
Treatment 3: _____

Please confirm that your profile, including your medical history has not changed since your last treatment.

Client / Patient Signature: _____
Skin Specialist: _____
Date: _____
Treatment 4: _____

Please confirm that your profile, including your medical history has not changed since your last treatment.

Client / Patient Signature: _____
Skin Specialist: _____
Date: _____
Treatment 5: _____

Please confirm that your profile, including your medical history has not changed since your last treatment.

Client / Patient Signature: _____
Skin Specialist: _____
Date: _____
Treatment 6: _____

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