VI Peel ® Consent Form

I _____(Patient Name) hereby authorize _____ (Medical Provider and/or esthetician) to perform chemical peel treatments. The medical provider and/or esthetician obtained my medical history and found me eligible for treatment.

PEEL TYPE: _____ LOT # _____ EXP DATE: _____

TREATMENT: The VI Peel® contains a synergistic blend of powerful ingredients suitable for all skin types. VI Peel® will improve the tone, texture and clarity of the skin; reduce age spots, improve hyperpigmentation (including melasma), soften lines and wrinkles; clear acne skin conditions; reduce or eliminate acne scars; and stimulate the production of collagen, for firmer, more youthful skin.

CONTRAINDICATIONS:
- Patients who are pregnant or who are breast-feeding
- Patients who have an aspirin, hydroquinone or phenol allergy
- Patients who have used oral isotretinoin (Accutane) within the past 6 months
- Patients who have active cold sores, warts, open wounds or history of herpes simple
- Patients who are undergoing chemotherapy and or radiation therapy within 6 months
- Patients with an autoimmune (i.e. Lupus) disorder, liver disease, or any condition that may weaken the immune system

Note: Please read the following information below, then initial if you understand and agree with each statement

_____ Prior to receiving treatment I have communicated with the practitioner about any conditions or medications that may contraindicate this procedure.

_____ I understand that there may be some degree of discomfort such as burning, stinging, redness, heat or tightness during and a week after the procedure.

_____ I understand that there is no guarantee of the final results of the peel. Occasionally hyperpigmentation may develop which may persist for a week or months after the peel.

_____ I understand although complications are very rare, sometimes they may occur. In the event of any complications, I will immediately contact the Physician/Clinician who performed the treatment.

_____ I understand if I have any acne condition in the skin, the peel may bring out oils and bacteria from below the surface and can cause an actual breakout.

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_____ I understand that multiple VI Peel® treatments may be necessary to maintain results

_____ I understand the direct sun exposure including tanning beds are strictly prohibited before and after the VI Peel®.

_____ I understand no activities involving excessive sweating can be done for 72-96 hours (exercise, sauna, hot tub steam room and that overheating may cause me to develop blisters or cause hyperpigmentation to worsen.)

_____ I will protect my skin with SPF 50+ and avoid sun exposure during the 7 day exfoliation process.

_____ I understand that no other chemical peels, facial machine brushes or medical device (laser, IPL, etc.) treatments may be performed on my skin until my physician/clinician determines it is safe to do so.

MEDICAL HISTORY: I have informed the medical provider of all my known allergies and all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, antiplatelet or anticoagulation medications. I have been advised about which of these medications I should avoid taking on the days surrounding the procedure. I understand that the medical provider will rely on my documented medical history, as well as other information obtained from me in determining whether to perform this procedure. I have provided and agree to continue to provide accurate and complete information about my medical history and conditions. I am not pregnant/nursing and do not have any contraindication to this procedure.

FOLLOW-UP: I agree to follow up with the medical provider at the recommended intervals at the Valley Health Clinic office location(s) and to contact the clinic if there is any change in my condition, medical history or any problem I may experience. I agree to call the office immediately and should any unusual side effects occur. I understand that in case of a medical emergency, I should call 911 or go to an emergency medical facility.

CONSENT FOR TREATMENT: The procedure has been explained to me and my questions regarding such treatment, its alternative, its complications, and its risk have been answered. The information provided is clear and I understand the risks/complications of the treatment. My questions have been fully answered and I have read this document to understand its contents. I understand that there are no guarantees, all sales are final and payment is due at time of treatment. I understand that I will continue to age and may need additional treatments/products in the future. I understand that aesthetic treatments are not going to take care of all my aging skin needs. I hereby give my unrestricted informed consent for treatment of designated aesthetic procedure/product. I also understand that this consent is valid for future treatments unless the policies of the office or the known risks for the procedure/product change. By signing this form I acknowledge that guarantees as to the final results of my treatment have not been made. THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.

Initials: _____ I release the device manufacturer, medical provider/injector(s), and staff of Valley Health Clinic LLC and Revive Aesthetics LLC from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products.

Initials: _____ I authorize before, during and after the procedure(s) the taking of photographs to be part of my patient profile that may be used for educational, promotion or advertising purposes without disclosing my identity. I also release Valley Health Clinic LLC and its associated staff including Revive Aesthetics LLC from any liability in connection with the use of such photographs and/or videos. My name will not be used to identify these photographs without my written approval.

_____	_____	_____
Patient Name Printed	Patient Name Signed	Date

_____	_____	_____

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VHC
Valley Health Clinic

Chemical Peel Consent Form

GLYTONE PEEL, VITALIZE PEEL, REJUVENIZE PEEL, or OTHER

I _____(Patient Name) hereby authorize _____ (Medical Provider and/or esthetician) to perform chemical peel treatments. The medical provider and/or esthetician obtained my medical history and found me eligible for treatment.

PEEL TYPE: _____ LOT # _____ EXP DATE: _____

TREATMENT: Chemical peels range from very superficial to superficial, designed to improve the texture and appearance of your skin. Potential benefits of chemical peel includes improvement of tone, texture and clarity of the skin; reduction of age spots; ameliorating hyperpigmentation (including melasma); soften lines and wrinkles; clear acne skin conditions; reduce or eliminate acne scars; and stimulate the production of collagen for firmerm, more youthful skin.

CONTRAINDICATIONS:

Please read carefully and notify your provider if any of the following apply to you.

- Patients who are pregnant or breastfeeding (lactating)
- Patients with active cold sores or warts, skin with open wounds, sunburn, excessively sensitive skin, dermatitis or inflammatory rosecea in the area to be treated.
- Patients with any history of herpes simplex that have an active outbreak/lesion. If you have a history of herpes, please make your provider aware to consider empiric treatment prior to chemical peel.
- Patients with a history of allergies (especially allergies to salicylates like aspirin), rashes, or other skin reactions, or those who may be sensitive to any of the components in this treatment
- Patients who have taken Accutane within the past year
- Patients who have received chemotherapy or radiation therapy
- Patients with vitiligo or other hypo/hyperpigmentation skin conditions
- Patients with a history of an autoimmune disease (such as rheumatoid arthritis, psoriasis, lupus, multiple sclerosis, etc.) or any condition that may weaken their immune system

PRE-TREATMENT INSTRUCTIONS:

Note: The use of these products/treatments prior to your peel may increase skin sensitivity and cause a stronger reaction.

Please note that FOUR week before a chemical peel, it is required that you AVOID these products and/or procedures

- Electrolysis, Waxing , Depilatory Creams, or Laser Hair Removal
- Patients who have had BOTOX® injections should wait until full effect of their treatment is seen before receiving a chemical peel, which is typically at least 2 weeks out from the time of injections

Please note that TWO week before a chemical peel, it is required that you AVOID these products and/or procedures

- Retin-A®, Renova®, Differin®, Tazorac® products
- Any products containing retinol, alpha -hydroxy acid (AHA) or beta-hydroxy acid (BHA), or benzoyl peroxide
- Any exfoliating products that may be drying or irritating

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