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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Med Spa Services Supervised by Medical Director Dr. Abdullah Farooque MD

**POTENTIAL RISKS/COMPLICATIONS:**
It is common and expected that your skin will be red, possibly itchy and/or irritated. It is also possible that other adverse experiences (side effects) may occur. Although rare, the following adverse experiences have been reported by patients after having a chemical peel: skin breakout or acne, rash, swelling, and burning.

Call the office immediately at _____if you have any unexpected problems after the procedure. If we are closed, contact your primary care provider (PCP).

Although most people experience peeling of their facial skin, not every patient notices that their skin peels after a chemical peel procedure. Lack of peeling is NOT an indication that the peel was unsuccessful. If you do not notice actual peeling, please know that you are still receiving all the benefits of the chemical peel, such as: stimulation of collagen production, improvement of skin tone and texture, and diminishment of fine lines and pigmentation. There are a number of reasons why a patient may not have peeling or may experience minimum peeling. The reasons may include:

• Having peels regularly with a short interval between peels
• Frequent use of Retin-A, AHA, or other peeling agents prior to the chemical peel treatment
• Severe sun damage

**Please read below then initial next to each statement if you agree with the following:**

_____I do not have any of the conditions that are contraindicated for the treatment of a chemical peel

_____ I understand that the actual degree of improvement cannot be predicted or guaranteed.

_____ I understand that I may need several of these peels to achieve optimal results.

_____ I understand that for optimum results the post-peel care instructions must be followed utilizing skin care products recommended by your provider

**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 TO TREAT:** The procedure has been explained to me and my questions regarding such treatment, its alternative, its complications, and its risk have been answered. I understand the risks/complications of the treatment. 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.



**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.

THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.

| _____ | _____ | _____ |
|---|---|---|
| Patient Name Printed | Patient Name Signed | Date |

| _____ | _____ | _____ |
|---|---|---|
| Medical Provider Name Printed | Medical Provider Name Signed | Date |



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