CIRCADIA
by Dr. Pugliese
Advanced Professional Skincare

INFORMED CONSENT FOR CHEMICAL PEEL

Initial on line

I, _____, give permission to my skin care professional, _____, to perform the Circadia chemical peel treatment:

☐ Lactic ☐ Alpha/Beta ☐ Jessner's ☐ DermaFrost Salicylic ☐ MandeliClear

_____ 1. I agree to complete a Confidential Skin Health Questionnaire. I agree to complete and be truthful about my physical conditions, pregnancy, medications that I may be taking, and my current skin care regimen. I am also aware that my lifestyle, which if it includes smoking, outdoor exposure, tanning beds, excessive alcohol consumption and/or recreational use of controlled substances, will effect and diminish the effectiveness and result of the treatment.

_____ 2. I have disclosed to my skin care professional/esthetician any surgical procedures, laser treatments or facial procedures that I have had or intend on having in the future.

_____ 3. I am not presently pregnant or lactating

_____ 4. I have not had any recent chemotherapy or radiation treatments

_____ 5. I have not recently waxed or used a depilatory (such as Nair) on the area being treated today. I do not have a history of keloid scarring, diabetes, any autoimmune disease, active herpes blisters or cold sores.

_____ 6. I have not had any other peel treatment of any kind within 14 days of treatment. I understand I cannot have another treatment within 14 days of this treatment, whether the treatment is performed at this location or any other location.

_____ 7. I agree to refrain from excessive sun exposure or the use of a tanning bed while I am undergoing treatment and during the 14 days following the end of the treatment.

_____ 8. I understand that sun exposure is prohibited while I am undergoing treatment and that the use of Circadia Light Day Broad Spectrum Sunscreen SPF 37 is mandatory.

_____ 9. I understand the purpose of this peeling procedure is to exfoliate the outer surface of my skin. Some of the benefits include lessening of pigmentation, reduction in appearance of fine lines and wrinkles, and control of certain conditions such as acne or occasional breakout.

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_____ 10. I understand that the following conditions preclude me from having this treatment at this time and verify that none of these conditions apply to me at this time.

_____ Allergic to aspirin or any salicylic sensitivity (DermaFrost contains salicylic acid).
_____ Broken skin on areas to be treated
_____ Sunburn or windburn skin
_____ Visible inflammatory or inflammatory lesions
_____ Recent peels within eight weeks
_____ Herpes virus (cold sores) on mouth
_____ Use of Accutane® within the past 12 months
_____ Use of glycolic acid products
_____ Use of Retin-A®, Renova®, retinoids (Vitamin A) in the last 4 weeks

_____ 11. My expectations are realistic and I understand that the results are not guaranteed and that for maximum results, more than one application may be necessary. The rate of improvement depends on my skin type, condition, my age, degree of sun damage, or pigmentation levels.

_____ 12. I understand the cost of treatment and the fee structure has been explained to me.

_____ 13. I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complication, I will immediately contact the skin care professional who performed the treatment.

_____ 14. I understand of the possibility of peeling, flaking, hyperpigmentation and excessive dryness. I agree to use the products specifically recommended by my skin care professional/esthetician and including a sunscreen.

_____ 15. I understand that every precaution will be taken to minimize or eliminate negative reactions such as blisters, redness, or irritation.

_____ 16. I understand that my practitioner will recommend home care products to work in tandem with the in-clinic treatment. I am willing to follow recommendations by my skin care professional for home care.

_____ 17. I consent to the taking of photographs to monitor treatment effect and results if desired by my therapist.

INFORMED CONSENT

In the event of any questions or concerns, I will consult my skin care professional immediately. I understand the potential risks and complications and I have chosen to proceed with the treatment after careful consideration of both known and unknown risks, complications, and limitations. I will hold the skin care professional and staff harmless from any liability that may result from this treatment.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

Client Signature _____ Date _____

Skin Care Professional _____ Date _____

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