GLYTONE

PROFESSIONAL

by ENERPEEL®

PATIENT INFORMED CONSENT FORM

These are suggested inclusions to be implemented into your current consent form

ATTACHMENT A

Informed Consent Form [to be downloaded to healthcare professional's office letterhead]
The patient declares that

- He/She consents to treatment with the GLYTONE by ENERPEEL® peel containing _____ acid
- He/She has been fully and completely informed of the exfoliation treatment with GLYTONE by ENERPEEL® product ____ _____, including all the possible side effects including pain and scarring
- He/She understands and does not meet any of the exclusionary criteria
- He/She will comply with the post-treatment procedures to be followed including the required use of sunscreen, which is to be applied during each day of treatment, including a peel series
- He/She was given informational literature and read and understood said informational literature including benefits/risks/ outcomes and their suitability for the product
- He/She was given the opportunity to ask questions and these questions were answered to their complete satisfaction and understanding
- He/She understands the effect and nature of the treatment as well as possible alternative treatments
- He/She has been advised that although good results are expected, the product is not guaranteed to be effective nor can there be any guarantees against negative or unexpected outcomes
- He/She has not used Oral Isotretinoin within the past 6 months
- He/She has not used topical retinoids, including Differin (Adapalene), Retin-A (Tretinoin), Renova (Tretinoin), or Tazorac (Tazarotene) within the past 10-15 days
- He/She will not wax their face or other areas to be treated within 10-15 days prior to treatment and will not wax their face or other treated areas during the course of treatment.

The Patient declares that he/she has thoroughly considered the information provided in the information leaflet, is knowledgeable of the chemical exfoliation procedure that will be carried out, and accepts the risk of a negative or untoward outcome including scarring and excessive pain. The Patient authorizes the above referenced exfoliation treatment.

Signature: _____

Medical Strength Peels
Client Informed Consent Form

To the CLIENT: You have a right to be informed about your condition and its treatment, so that you may decide whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give, or withhold, your consent for treatment.

1. I voluntarily request that _____ perform the Medical Strength Peel procedure. I acknowledge having been informed that this cosmetic procedure is intended to remove surface layers of the skin to improve the vitality of the skin.

2. Medical strength peels, despite their high levels of efficacy and safety, are not free of side effects. Erythema (redness) and edema (swelling) of the treated area can occur but usually subsides within a few hours but can last up to seven days or longer. Irritation, itching, and/or mild burning sensation or pain similar to sunburn may occur within 48 hours of treatment.

3. Pigmentary changes such as hyper pigmentation and hypo pigmentation of the skin in the treated areas can occasionally occur. Mostly it is transient, lasting up to six months, but in rare cases it can be permanent. These pigmentary changes may occur despite appropriate protection from the sun so it is important to use sun screen of SPF 25 or greater when exposed to the sun.

4. I understand complications can include white heads, cold sores, infection, scarring, numbness and permanent discoloration, particularly in people with dark skin.

5. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. I am aware that follow-up treatments may be necessary for desired results. Most patients require a number of treatments over several months with gradual results occurring over this time. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for treatments received.

6. I have read and understand the Pre and Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre and post procedure guidelines are crucial for healing, prevention of scarring, and other side effects and complications such as hyper pigmentation, hypo pigmentation, and other skin textural changes.

I understand and agree that all services rendered to me are charged to me directly and that I am personally responsible for payment.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

I release_____, medical staff, and specific technicians from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

Note: All prices are subject to change without prior notice

Client's Name (Please Print):_____

Client's Signature:_____

Date:_____ Time:_____

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name _____ Today's Date_____

Date of Birth_____ Age _____ Occupation_____

Home Address_____ City_____ State___ Zip Code_____

Home Phone ( ) _____ Work Phone (___)_____

Emergency Contact Name and Phone_____

How were you referred to us?_____

Which of the following best describes your skin type? (Please circle one type number)

I Always burns, never tans

II Always burns, sometimes tans

III Sometimes burns, always tans

IV Rarely burns, always tans

V Brown, moderately pigmented skin

VI Black skin

MEDICAL HISTORY

Are you currently under the care of a physician? Yes No
If yes, for what:

Are you currently under the care of a dermatologist? Yes No
If yes, for what:

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? " Yes No

Do you have any of the following medical conditions? (Please circle all that apply)
Cancer Diabetes High blood pressure Herpes Arthritis

Frequent cold sores HIV/AIDS Keloid scarring Skin disease/Skin lesions "

Seizure disorder Hepatitis Hormone imbalance Thyroid imbalance

Blood clotting/ abnormalities Any active infection

Do you have any other health problems or medical conditions? Please list: _____
_____

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced) ❑Food ❑Latex ❑Aspirin ❑Lidocaine ❑Hydrocortisone ❑Hydroquinone or skin bleaching agents ❑Others:

MEDICATIONS

What oral medications are you presently taking? ❑Birth control pills ❑Hormones

❑Others (Please list): _____

Are you on any mood altering or anti-depression medication?_____

Have you ever used Accutane? ❑Yes ❑No If yes, when did you last use it?_____

What topical medications or creams are you currently using? ❑ RetinA , ❑Others (Please list):

_____

What herbal supplements do you use regularly?_____

HISTORY

Have you ever had laser hair removal? ❑Yes ❑No

Have you used any of the following hair removal methods in the past six weeks?

❑Shaving ❑Waxing ❑Electrolysis ❑Plucking ❑Tweezing ❑Stringing ❑Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? ❑Yes ❑No

Have you recently used any self-tanning lotions or treatments? ❑Yes ❑No

Do you form thick or raised scars from cuts or burns? ❑Yes ❑No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ❑Yes ❑No If yes, please describe: _____

_____

For our female clients:

Are you pregnant or trying to become pregnant? ❑Yes ❑No Are you breastfeeding? ❑Yes ❑No

Are you using contraception? ❑Yes ❑No

I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Signature_____ Date:_____

Medical Peels
After Care Form
Skin Deep Day Spa

After the procedure (7-14 days):

- Avoid sun exposure by wearing protective clothing and/or sunscreen
- Do not rub or scratch the areas that were treated
- Do not pull on skin to facilitate peeling
- Avoid using any products containing Retinoids and other drying, peeling agents
- Do not use scrubs or abrasive cleansers
- Wait for a minimum of 2 hours before applying water
- Avoid strenuous exercise for 24 hours
- Avoid tweezing, waxing, bleaching, or laser services during the course of this treatment. Do not use any irritants such as Retin-A, Benzoyl Peroxide, or astringents.