Radiance
Medspa DC

CONSENT FORM – MICRODERMABRASION TREATMENT

I _____(Patient's Name) authorize Radiance MedSpa DC Clinicians, and/or assigned designee to perform the procedure of *Microdermabrasion (Silk Peel)*.

Please Initial Below:

_____ I acknowledge that this Consent Form encompasses the procedure performed as described above, as well as repeat treatments performed at any given time or as part of a series. Further, this consent shall be valid until expressly revoked by me.

_____ The nature and purpose of this treatment have been explained to me and any questions I have regarding the treatment have been answered to my satisfaction.

_____ I understand that the treatment may involve risks of complications from both known and unknown causes, and I freely assume these risks. Possible side effects of the treatment may include, but are not limited to, mild redness of the skin, dry skin, flaking, irritation, mild discomfort and/or cold sores.

_____ Due to the nature of this treatment, an exact result cannot be predicated and I acknowledge that no guarantees have been made to me as to the results that may be obtained. I further understand that no promises of permanence have been made to me regarding microdermabrasion treatments.

_____ I have received and understand the post skin care recommendations.

_____ If pre and post operative photos and/or videos are taken of the treatment for record purposes, I understand that these photos will be the property of the attending physician.

_____ I understand that multiple treatments may (often) be required to produce the desired results.

_____ Should one or more foregoing problems arise, please notify the office immediately. Early detection and treatment may minimize future complications.

I certify that I have read this entire CONSENT FORM and that I understand and agree to the information provided orally and in this form. I certify that I am a competent adult of at least 18 years of age, or, that if I am a minor under the age of 18, I understand the consent of my parent/legal guardian/person of legal custody will also be required before treatment.

_____ _____

Patient Signature/Date Witness Signature/Date

_____

Clinician Signature/Date