DERMAPLANE
DISCLOSURE & CONSENT FORM

Dermaplaning is a physical/mechanical form of exfoliation using a specialized dermaplaning blade for the removal of built up dead skin cells and vellous hair. Following treatment skin will be smoother, softer and better able to absorb the active ingredients in treatment and home care products.

Please read and initial the following:

_____I understand I am receiving an exfoliation treatment using a sterile surgical blade which removes most, not all vellus hair (peach fuzz) and as with the use of any sharp instrument, there is the possibility of nicks or cuts.

_____I understand the results of this treatment may vary due to conditions such as age, condition of skin, sun damage, climate, etc. and this treatment is a cosmetic treatment in which no medical claims are expressed or implied.

_____I have read and understood prior to the treatment the benefits and outcome of the service.

_____I understand with ANY beauty service there are inherited risks, including but not limited to allergic reactions. Understanding potential side effects may include, grazing, abrasions, skin sensitivity or adverse reactions to products used during treatment.

_____I understand I must follow my aftercare to prevent potential skin irritations and that direct sun exposure, including tanning beds, is not recommended while undergoing treatment and the use of a daily sun block protection is mandatory.

_____I understand there are contraindications to this treatment, including but not limited to, diabetes (not controlled by diet or medication), cancer, active acne, bleeding disorders, the inability for blood to coagulate or the development of keloids following injury. Certain medications including blood thinners, higher dosages of Aspirin, and Accutane are contraindicated for this treatment due to the possibility of delayed clotting from a nick or cut. I certify that I am not taking any of the above medications or experiencing any of the above conditions.

_____I understand that not providing the required information regarding what I do before or after the treatment may affect the results, and do not hold the Esthetician or Serenity Day Spa & Salon, Inc. responsible.

Please check if you are using any of the following:

- ☐ Vitamin A (retinol, retain A, retinyl palmitate)
- ☐ AHA's (Glycolic, Lactic, Malic, Tartaric, Citric, Mandelic acids)
- ☐ BHA's (Salicylic acid)
- ☐ Roaccutane
- ☐ Skin antibiotics
- ☐ Prescriptive skin creams

☐ Diabetic medications or blood thinners

Please check if you suffer from any of the following:

☐ Facial skin cancers

☐ Acne

☐ Rosacea

☐ Facial skin tags

☐ Facial psoriasis, eczema or dermatitis

☐ Herpes simplex virus

_____I give my permission to photograph my face and these photos may be used in her portfolios, as an expert witness, advertising, or for educational purposes without any present or future payment to me.

_____I am 18 years of age or older and have informed the skin care specialist of any physical or psychiatric health problems that would prevent me from having this procedure performed, and I know of no reason why I should not have these procedures performed on me. I understand that temporary redness, swelling, bruising and discomfort occur from this procedure. Possible complications that could occur include, but are not limited to, risk of infection, allergy or sensitivity to local anesthetics and inconsistent results. I will also seek medical attention as recommended by skin care specialist if necessary and understand that I am responsible for the full payment of expenses incurred in the event this is necessary.

This procedure is being performed under standard sanitizing and sterilizing methods as recommended by the Centers for Disease Control and as required by the State Department of Health. All needles used of are disposed of properly after each procedure.

In consideration of the skin care specialist providing me with the service requested, I for myself, my spouse, legal representatives, heirs, and assigns, hereby release, waive and discharge the skin care specialist along with Serenity Day Spa & Salon, Inc. from liability for all loss of damage on account of or injury to person. I understand several procedures are necessary to achieve the desired effect and agree to complete my treatments as recommended. Should I not complete treatments, I will be responsible for any adverse outcome.

I expressly agree that this consent, waiver, and indemnity agreement is intended to be as broad and inclusive as permitted by the laws in the State of Georgia. I have read this consent and understand all its terms and execute this release voluntarily, and with full knowledge of its significance. All my questions have been answered satisfactorily prior to signing of this consent.

Client Signature_____ Date:_____

Witness Signature_____ Date:_____