

## PATIENT/CLIENT INFORMATION

DATE \_\_\_\_\_ HOME PHONE \_\_\_\_\_  
 NAME \_\_\_\_\_ WORK PHONE \_\_\_\_\_  
 ADDRESS \_\_\_\_\_ CELL \_\_\_\_\_  
 CITY/STATE/ZIP \_\_\_\_\_ EMAIL \_\_\_\_\_  
 FAX \_\_\_\_\_

## TREATMENT (Please initial by each statement)

\_\_\_\_\_ The treatment was explained to me in detail.  
 \_\_\_\_\_ The benefits of what I can realistically expect to see from my Clinical Peel have been fully explained to me.

## TREATMENT (Please select one)

\_\_\_\_\_ ORMEDIC LIFT  
 \_\_\_\_\_ SIGNATURE LIFT  
 \_\_\_\_\_ LIGHTENING LIFT  
 \_\_\_\_\_ WRINKLE LIFT  
 \_\_\_\_\_ ACNE LIFT  
 \_\_\_\_\_ BETA LIFT  
 \_\_\_\_\_ PERFECTION LIFT  
 \_\_\_\_\_ TCA ORANGE PEEL

## SKIN CONDITION (Please select all that apply)

\_\_\_\_\_ SUPERFICIAL WRINKLES, FINE LINES  
 \_\_\_\_\_ DEEP WRINKLES, FINE LINES  
 \_\_\_\_\_ ACNE OR ACNE PRONE  
 \_\_\_\_\_ DEEP HYPERPIGMENTATION (SUN OR BROWN SPOTS)  
 \_\_\_\_\_ SEVERE PHOTOAGING  
 \_\_\_\_\_ ROSACEA  
 \_\_\_\_\_ DEHYDRATION  
 \_\_\_\_\_ ACNE SCARS  
 \_\_\_\_\_ UNBALANCED

## PRECAUTIONS (Please Read Carefully)

**The Treatment** you will receive is a clinical treatment designed to exfoliate or remove the outer layers of the skin.  
**Your participation** in your skin care treatments will determine the outcome. It is important that you strictly adhere to your home care products that your esthetician has recommended.  
**No guarantee** is expressed or implied as to the precise results, peeling times or discomfort.  
**During the treatment**, you may experience some temporary stinging or warm flushing. This will fade within a few minutes. During the next few hours, you may experience some tightening of the skin, which may last for several days.  
**For most patients**, flaking begins within 48 hours. It is impossible to pre-determine how much peeling will occur. The shedding process usually subsides within 5-7 days.  
**Depending on the clinical peel** performed and your skin quality, the following reactions may occur in some patients:  
 1) Prolonged redness, irritation & flakiness 2) Dryness and sensitivity 3) Severe allergic reactions in rare instances

## PLEASE INITIAL (Please Read Carefully)

_____ I AM NOT PREGNANT.**	_____ I DO NOT HAVE ACTIVE COLD SORES.
_____ I AM NOT ALLERGIC TO ASPIRIN.	_____ I HAVE NOT RECEIVED RADIATION TREATMENTS.
_____ I HAVE NOT USED GLYCOLIC FOR 24 HRS.	_____ I AGREE IT IS MANDATORY TO USE IMAGE POST PEEL KIT.
_____ I HAVE NOT USED RETINOL PRODUCTS FOR 72 HRS.	_____ I AGREE TO AVOID DIRECT SUN EXPOSURE FOR 2 WEEKS.
_____ I HAVE NOT TAKEN ACCUTANE IN THE PAST YEAR.	_____ I AGREE TO NOTIFY DR/AESTHETICIAN OF ANY CONCERNS. I
_____ I AGREE NOT TO PICK, PEEL, OR SCRATCH THE SKIN DURING HEALING PHASE.	_____ AGREE TO APPLY IMAGE PREVENTION + DAILY.
_____ I AGREE THERE MAYBE CRUSTING & SHEDDING OF SKIN.	_____ I AGREE NOT TO WAX FOR 7 DAYS PRE/POST TREATMENT.
_____ A PRIOR PATCH TEST HAS BEEN GIVEN TO ME TO RULE OUT ANY ALLERGIC TENDENCIES.	_____ I AGREE TO FOLLOW UP WITH SCHEDULED APPOINTMENT.
_____ I AGREE THAT I CURRENTLY DO NOT USE HYDROCORTISONE.	_____ I AGREE NOT TO USE RETIN-A PRODUCTS 5 DAYS PRE/POST TREATMENTS
	_____ I AM UNDER THE SUPERVISION OF A PHYSICIAN AND HAVE DISCUSSED THE TREATMENT PLAN WITH MY PHYSICIAN.

## CONSENT (Please sign)

I hereby give my consent and authorization voluntarily and release \_\_\_\_\_ (Name of business) from any claims, implied or stated that I have or may have in the future with this treatment, regardless of result. I am stating that the treatment and precautions above have been explained to me in detail and that I fully understand.

CLIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_ DATE: \_\_\_\_\_