OGA AESTHETIC & LASER CENTER

INFORMED CONSENT FOR MICRODERMABRASION

Please Initial Each

_____ I acknowledge that I have not used Accutane during the last six months.

_____ I acknowledge that if I am prone to Herpes (cold sores, fever blisters) that I may need a prescription for Zovirax (acyclovir) from my physician prior to having microdermabrasion. I will need to avoid exfoliating treatments during a breakout.

_____ I acknowledge that I must reveal any condition that may have a bearing on this procedure such as pregnancy, allergies, facial waxing, medication use, diabetes or immune deficiencies prior to receiving treatment.

_____ I acknowledge that there is no guarantee that dark discoloration of the skin (pigmentation, plasma) will be reduced or faded. Pigmentation may improve with successive treatments and proper skin care regimen.

_____ I acknowledge that my skin might experience temporary tightness, redness or slight swelling which usually dissipates within 24 hours depending on skin sensitivity.

_____ I acknowledge that if I fail to use adequate sunscreen (SPF 20) I am more susceptible to sunburn and skin damage.

_____ I acknowledge this treatment is strictly an elective cosmetic procedure and that no medical claims are expressed or implied.

_____ I acknowledge that I should avoid use of glycolic or Retina A type products for two to four days following microdermabrasion. I hereby agree to have microdermabrasion performed. I agree to follow all pre- and post- treatment instructions.

_____ _____

Client Signature **Date**