



## Chemical Peel Consent Form

The Chemical Peel procedure has been thoroughly explained. I realize that no promises or guarantees have been made. I understand that the treatment may be repeated several times to achieve complete satisfaction. I understand that this treatment is voluntary on my part. My signature below indicates that I have agreed to receive the Chemical Peel treatment(s). A chemical solution is used to peel away the skin's damaged outer layers. The new cells and collagen are stimulated during the healing process to produce a smoother, tighter, younger looking skin surface. A peel does not eliminate sagging or excess skin. Each treatment is customized for patient skin type, specific problem areas and the delicate areas of the face. The depth of the peel is dependent on the concentration and type of acid, the duration of the contact, and a person's skin type and sensitivity.

I have been told the following:

1. No anesthesia is needed for peels.
2. The peeling agent is applied evenly to the skin surface.
3. The agent is rapidly neutralized after several minutes with another solution.
4. I may experience some stinging, redness, irritation, and crusting.
5. It is common to experience some temporary flaking or scaling, redness and dryness of the skin.
6. I may immediately return to normal activities.
7. I have been instructed what to use to keep the skin clean and moist.
8. I have been instructed to begin or continue a regular program of sunscreen and sun protection

I acknowledge that I am obligated to follow The Dermatology Center of Newton & Rockdale instructions closely and visit the office as directed. I have been given ample opportunity for discussion and my questions have been answered to my satisfaction. I understand this treatment includes payment and the fee structure has been explained.

I have received no medication before signing this consent form. Initial \_\_\_\_\_

I have not been on the prescription Accutane in the past 12 months. \_\_\_\_\_

I am not prone to Herpes (cold sore) outbreaks.

PatientName (Please Print): \_\_\_\_\_

PatientSignature: \_\_\_\_\_

GuardianSignature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Signature: \_\_\_\_\_