

Dermaplaning

Overview & Consent Form



Full Name: _____	Referred By: _____
Phone Number: _____-_____-____	Email: _____

You have the right to be informed about your treatment, so you may decide whether or not to undergo the procedure after knowing the risks and benefits involved. This disclosure is an effort to make you better informed so that you may give or withhold your consent for treatment.

(After reading each of the following, please initial on the line provided)

_____ I understand that Derma planning involves using a sterilized surgical blade to remove fine vellus hair from the face and provide light exfoliation.

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

_____ I understand that the treatment may involve the risk of complication or injury and I freely assume those risks. Possible side effects of the treatment area can include mild redness, mild irritation, and dryness. Additionally, nicks to the skin can occur due to the sharp surgical blade.

_____ The hair that grows back will not be darker or thicker, however, I do understand that any hormone imbalance present within my anatomical system can alter the normal hair growth pattern.

_____ If a chemical Peel is included with this treatment, I understand that the sensation and penetration of the peel will be enhanced. This may cause skin irritation, mild discomfort, tenderness, lightening or darkening of the skin, infection, scarring, peel, and activation of cold sores when the virus is already present in the body.

_____ I certify that I have read this entire consent form and I understand and agree to the information provided in this form

_____ I certify that I'm at least 18 years of age or have a parental consent signed below.

_____ I will call to inform my esthetician of any complications or concerns as soon as they occur.

I certify that I read the above content and I fully understand it and give my consent to the Dermaplaning treatment

Client Signature: _____

Date: ____/____/____

Esthetician Signature: _____

Date: ____/____/____