



DERMAPLANING CONSENT

I understand that Dermaplaning involves the use of a surgical blade to remove fine vellus hair and dead layers of skin from the face.

The nature and purpose of this treatment has been explained to me and any questions I have regarding the treatment have been answered to my satisfaction.

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 of the skin, irritation and dryness. Additionally, nicks to the skin can occur due to the sharp surgical blade. Patient will be notified and the area will be treated if necessary. New hair growth will not appear darker or denser. However, I do understand that any hormonal imbalance that may be present within the anatomical system can alter hair growth pattern.

If a chemical peel is part of the treatment: I understand that the sensation and the penetration of the peel will be enhanced. Which may cause skin irritation, mild discomfort, tenderness, lightening or darkening of the skin, infection, scarring, peeling, and activation of cold sores.

I certify that I have read this entire consent document and that I understand and agree to the information provided in this form. I certify that I am a competent adult of at least 18 years of age, or that, if I am a minor under the age of 18, I understand that the consent of my parent/guardian having legal custody over me will also be required to sign this consent document prior to any treatment. I agree and adhere to all safety precautions and regulations during the Dermaplaning treatment.

Patient Signature: _____ **Date:** _____

Guardian Signature: _____ **Date:** _____

Witness: _____ **Date:** _____