DOCTORS OF INTERNAL MEDICINE

PATIENT CONSENT FORM
FOR CHEMICAL PEEL THERAPY

I HEREBY AUTHORIZE DR._____ OR _____, UNDER DR. _____'S SUPERVISION TO PERFORM JESSNER CHEMICAL PEEL THERAPY. I UNDERSTAND THAT THIS PROCEDURE WORKS ON PROMOTING VIBRANT AND HEALTHY LOOKING SKIN. I UNDERSTAND THAT MULTIPLE TREATMENTS ARE REQUIRED AND IT IS POSSIBLE THE RESULT WILL BE MINIMAL OR NOT HELP AT ALL.

I AM AWARE OF THE FOLLOWING POSSIBLE EXPERIENCES/RISKS: (PLEASE INITIAL)

_____ MY SKIN CARE SPECIALIST HAS ANSWERED ANY QUESTIONS I HAVE REGARDING MY AFTERCARE. I ACKNOWLEDGE MY OBLIGATIONS TO CLOSELY FOLLOW AFTERCARE INSTRUCTIONS AND VISIT MY SKIN CARE SPECIALIST FOR A POST PEEL TREATMENT IF SPECIFIED.

_____ I AM AWARE AND ACKNOWLEDGE THAT THERE IS A RARE POSSIBILITY OF AN ALLERGIC REACTION. I HAVE DISCUSSED THOROUGHLY WITH MY SKIN CARE SPECIALIST ANY SUCH REACTIONS AND UNDERSTAND THEM.

_____ I HAVE BEEN OFFERED A PATCH TEST TO CHECK FOR SENSITIVITY. I AM WILLING TO FOREGO A PATCH TEST BUT UNDERSTAND THERE COULD BE AN ALLERGIC REACTION.

_____ I HAVE BEEN ADVISED THAT MY TREATMENT IS A NON-INVASIVE, EPIDERMAL EXFOLIATION. THIS PROCEDURE STIMULATES THE SKIN TO GENERATE NEW SKIN CELLS, PRODUCE NEW COLLAGEN, AND INCREASE THE BLOOD FLOW CIRCULATION OF THE SKIN. THIS DOES NOT REPLACE DEEP CHEMICAL PEELS, LASER RESURFACING, OR PLASTIC SURGERY.

_____ I ACKNOWLEDGE THAT DURING APPLICATION I WILL NOTICE A WARM SENSATION, AND THE SKIN MAY TINGLE, STING, OR BURN. IMMEDIATELY AFTER THE PEEL MY FACE MAY APPEAR FROSTED OR SUNBURNED. BY DAY TWO, THE SKIN MAY DARKEN IN COLOR, FEEL TIGHTER, AND BECOME MORE SENSITIVE. ON DAYS TWO THROUGH SEVEN THE PEELING PROCESS BEGINS. I AM NOT TO PICK OR PEEL AT THE OLD SKIN. PULLING OR PICKING SKIN MAY LEAD TO INFECTION OR SCARRING. I MAY EXPERIENCE BREAKOUTS DURING THIS PROCESS.

_____ SCARRING, SCABBING, AND LONG TERM PIGMENTARY CHANGES ARE POSSIBLE RISKS INVOLVED IN CHEMICAL PEELS, AND ARE MORE LIKELY IN PEOPLE THAT ARE NOT HONEST ABOUT THEIR TANNING HABITS OR WHO TAN DURING THE COURSE OF THEIR TREATMENTS. ARTIFICIAL TANNING AND SUN EXPOSURE MUST BE AVOIDED FOR 14 DAYS POST TREATMENT. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO AVOID THE SUN AND LET MY SKIN CARE SPECIALIST KNOW IF I HAVE RECEIVED ANY TAN DURING THE COURSE OF MY TREATMENT.

_____ I UNDERSTAND THAT I MUST USE A FULL SPECTRUM SUN BLOCK WITH A MINIMUM SPF OF 30 DAILY. A NON-CHEMICAL SUN BLOCK SUCH AS TRANSPARENT ZINC OXIDE IS LESS IRRITATING TO SENSITIVE SKIN.

_____ I ACKNOWLEDGE THAT I HAVE NOT BEEN ON ACCUTANE DURING THE PAST SIX MONTHS. I ACKNOWLEDGE THAT I HAVE NOT USED RETIN-A OR RENOVA FOR THE PAST TWO WEEKS. I WILL ALSO AVOID THE USE OF RETIN-A, RENOVA, ALL FORMS OF SCRUBS, AND AN ALPHA OR BETA HYDROXYL TYPE PRODUCT FOR 14 DAYS OR UNTIL SENSITIVITY HAS SUBSIDED.

_____ I ACKNOWLEDGE THAT I AM PRONE TO COLD SORES (HERPES); I MAY NEED A PRESCRIPTION FROM MY PHYSICIAN PRIOR TO HAVING A PEEL. I AM AWARE THE TREATMENT COULD BRING ABOUT COLD SORES.

_____ I UNDERSTAND THAT ANY TIME THE SKIN BARRIER IS BROKEN; THERE IS A SMALL RISK OF BACTERIAL OR VIRAL INFECTION. I WILL CONTACT ADVANCED SKINCARE SOLUTIONS IMMEDIATELY IF I SUSPECT INFECTION.

_____ I ACKNOWLEDGE THAT I AM NOT ASPIRIN SENSITIVE OR IF I AM I HAVE DISCUSSED THIS WITH MY SKIN CARE SPECIALIST AND UNDERSTAND THAT THERE COULD BE A REACTION.

_____ I HEREBY AUTHORIZE ADVANCED SKINCARE SOLUTIONS OR ANY ASSOCIATES TO TAKE PICTURES OF THE TREATED AREA IN MY PATIENT FILE AND/OR FOR TEACHING PURPOSES. I UNDERSTAND THAT THE RELEASE OF THIS INFORMATION WILL BE KEPT CONFIDENTIAL AND THAT NO PATIENT NAMES WILL BE USED.

_____ I HAVE RECEIVED A COPY OF THE INSTRUCTIONS DOCUMENT FOR THIS PROCEDURE.

I ACKNOWLEDGE THE FOLLOWING POINTS HAVE BEEN DISCUSSED WITH ME:

- POTENTIAL BENEFITS OF THE PROPOSED PROCEDURE, INCLUDING THE POSSIBILITY THAT THE PROCEDURE MAY NOT WORK FOR ME
- ALTERNATIVE TREATMENTS SUCH AS TOPICALS, MICRODERMABRASION, OR SURGERY
- REASONABLY ANTICIPATED HEALTH CONSEQUENCES IF THE PROCEDURE IS NOT PERFORMED.
- POSSIBLE COMPLICATIONS/RISKS INVOLVED WITH THE PROPOSED PROCEDURE AND SUBSEQUENT HEALING PERIOD

FOR WOMEN OF CHILDBEARING AGE: BY SIGNING BELOW I CONFIRM THAT I AM NOT PREGNANT AND DO NOT INTEND TO BECOME PREGNANT ANYTIME DURING THE COURSE OF TREATMENT. FURTHERMORE, I AGREE TO KEEP DR._____ AND STAFF INFORMED SHOULD I BECOME PREGNANT DURING THE COURSE OF TREATMENT.

ACKNOWLEDGMENT

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FOR CHEMICAL PEEL THERAPY, AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.

_____ _____ _____

SIGNATURE-PATIENT OR GUARDIAN PRINT NAME/RELATIONSHIP DATE

_____ _____ _____

SIGNATURE-WITNESS PRINT NAME DATE

CHEMICAL PEEL

Post-Care Instructions

FIRST DAY

- Do nothing to skin following treatment until following day
- Avoid any/all sun exposure
- Use cool compresses and hydrocortisone cream
- Avoid retin-a or alpha hydroxy acids.
- If swelling or irritation occurs, please call our office at 972-758-4455

SECOND DAY

- Skin may be tight and dry
- Do not use moisturizers
- Do not touch/pick at skin

THIRD DAY

- You may use a mild cleanser to clean skin
- Peeling may or may not begin
- Medium to heavy flaking
- Do not pick skin
- Avoid any/all sun exposure
- Must apply full spectrum sunscreen with spf 30 or higher
- Please follow up in one week

DAY 4 – DAY 7

- Return to normal skin care regimen with exception of Alpha Hydroxy acids or retin-a
- Any questions or complications please call us at 972-758-4455