



INFORMED CONSENT FOR DERMAPLANING

I GIVE MY CONSENT FOR DERMAPLANING TO BE PERFORMED. DERMAPLANING IS A PHYSICAL EXFOLIATION THAT REMOVES DEAD SKIN CELLS AND VELLUS HAIR FROM SURFACE OF THE FACE. THIS FORM OF EXFOLIATION SMOOTHS THE SKIN AND ALLOWS FOR THE ACTIVE INGREDIENTS IN SKINCARE PRODUCTS AND TREATMENTS TO PENETRATE DEEPER WHICH INCREASES THEIR EFFICACY & ANTI-AGING BENEFITS.

ALTERNATIVES TO DERMAPLANING INCLUDE MICRODERMABRASION AND SCRUBS FOR EXFOLIATION, AND WAXING, THREADING OR CREAM DEPILATORY FOR HAIR REMOVAL. THERE IS NO SINGLE TREATMENT TO REPLACE DERMAPLANING.

I UNDERSTAND THERE ARE CONTRAINDICATIONS TO THIS TREATMENT, INCLUDING BUT NOT LIMITED TO DIABETES, CANCER, ACTIVE ACNE, BLEEDING DISORDERS AND THE INABILITY FOR BLOOD TO COAGULATE FOLLOWING INJURY. CERTAIN MEDICATIONS INCLUDING BLOOD THINNERS, HIGHER DOSAGES OF ASPIRIN, ACCUTANE ARE CONTRAINDICATED FOR THIS TREATMENT DUE TO INCREASED SENSITIVITY AND/OR THE POSSIBILITY OF DELAYED CLOTTING FROM A NICK OR CUT.

I CERTIFY THAT I AM NOT TAKING ANY OF THE ABOVE MEDICATIONS OR EXPERIENCING ANY OF THE ABOVE CONDITIONS. ALTERNATIVE TREATMENTS SUCH AS WAXING TO REMOVE VELLUS HAIR AND MICRODERMABRASION FOR EXFOLIATION, ALONG WITH THEIR ASSOCIATED RISKS, HAVE BEEN EXPLAINED TO ME AS OTHER OPTIONS.

I UNDERSTAND THIS TREATMENT INVOLVES THE USE OF A SPECIALIZED DERMAPLANING BLADE TO REMOVE DEAD SKIN CELLS AND VELLUS HAIR. AS WITH THE USE OF ANY SHARP INSTRUMENT THERE IS A POSSIBILITY OF INJURY. WHILE EVERY PRECAUTION IS TAKEN, I UNDERSTAND THE RISKS AND CONSENT TO RECEIVE TREATMENT TODAY.

CLIENT SIGNATURE _____ DATE _____