



## CHEMICAL PEEL CONSENT

I hereby authorize Kingwood Skin Essentials or any delegated associates to perform a Chirally Correct Peel on me and acknowledge the following:

\_\_\_\_\_ I have completed the medical form accurately.

\_\_\_\_\_ I acknowledge my obligations to closely follow the post care instructions and visit my Skin Care Specialist for a post treatment as specified.

\_\_\_\_\_ I am aware and acknowledge that there is a rare possibility of an allergic reaction,

\_\_\_\_\_ The use of the above ingredients stimulates the skin to generate new skin cells. It does not replace deep chemical peels, laser resurfacing or plastic surgery.

\_\_\_\_\_ I acknowledge that there may be some degree of discomfort during application. I will notice a warm sensation and the skin may tingle, sting, pin pricking, heat (burn) or tightness. Immediately after the chemical exfoliation treatment, my face may appear frosted or red, and by day two(2) the skin may darken in color, feel tighter, and be more sensitive. Days two(2) through seven (7), the skin may exfoliate. I am not to pick or peel skin. Pulling or picking skin may lead to infection, hyperpigmentation and or surface scars. I may experience some breaking out after a treatment.

\_\_\_\_\_ I acknowledge that I will avoid direct sun exposure during this procedure and will apply a sunscreen daily.

\_\_\_\_\_ Chemical Exfoliation treatments may lighten hyperpigmented skin, reduce acne breakouts or diminish fine lines. I acknowledge that there is NO GUARANTEED result. I am aware that there could even be an increase of uneven color from this procedure.

\_\_\_\_\_ I acknowledge that I have not been using Accutane, Differin, Azelex, Finacea, Tazorac or any other prescribed medication (s) for the past two weeks.

\_\_\_\_\_ I acknowledge that if I am prone to cold sores (Herpes Simplex), I may need a prescription for Denavir, Zovirax or Abreva from my Physician prior to having a chemical exfoliation treatment. I am aware the treatment could bring about cold sores.

\_\_\_\_\_ I acknowledge that I am not aspirin sensitive. If I am aspirin sensitive, I have discussed this with my Skin Care Specialist and understand there could be a reaction.

\_\_\_\_\_ I acknowledge that to achieve maximum results, I may need several treatments and use home care products such as a prescription based Lightening cream and a form of Retinol for at least 2 weeks prior to getting each treatment and sunscreen for post care.

\_\_\_\_\_ I acknowledge that there are no guarantees as to results of this treatment, due to many variables, such as: age, condition of skin, sun damage, smoking, hormones, lifestyle, climate, etc. I understand I may not actually peel, and that each case is individual.

\_\_\_\_\_ I hereby agree to all of the above and agree to have this treatment be performed on me. I further agree to follow all post-peel care instructions as I am directed.

### ACKNOWLEDGEMENT

I understand and acknowledge that payments for the above procedure are non-refundable. By signature below, I certify that I have read and fully understand the contents of this consent form, and that the disclosures referred to herein were made to me.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Skin Care Specialist

\_\_\_\_\_  
Date