METROPOLITAN
ANTI-AGING • BEAUTY • WELLNESS

Name _____

Date of Birth _____

SKIN TREATMENT CONSENT FORM

☐ **Skin Treatment** ☐ **Chemical Peel** ☐ **LamProbe** ☐ **Hyfrecator**

At the Metropolitan Clinic, the well being of our patients is our top priority. Highly trained estheticians perform all skin care services. Please do not hesitate to discuss any concerns that you might have regarding your customized treatment plan.

Please initial next to each item:

_____ I am not pregnant or lactating
_____ I am not allergic to aspirin or citrus fruit
_____ I have not used Accutane in the last 6 months
_____ I have not used Retin-A or Retinols for the past week
_____ I do not have any active cold sores
_____ I have not had recent facial surgery
_____ I have not had chemotherapy or radiation treatments within the last 6 months
_____ I agree to follow the post care protocol provided to me by my technician
_____ I understand that if I have had any medical changes or new medications, I need to inform my technician of this before proceeding with the treatment.
_____ I understand that if peeling should occur, I should refrain from picking or pulling loose skin, as this could cause permanent scarring, and I agree to let the skin to fall off naturally.
_____ I understand that there are no guarantees as to the results of this treatment, due to many variables such as: age, condition of skin, sun damage, smoking, climate, etc.
_____ I understand that this is a cosmetic treatment and that no medical claims are expressed or implied.
_____ I understand that to achieve maximum results, several treatments are required and appropriate home care products must be used.
_____ I understand that although complications are rare, they may occur and that prompt treatment may be necessary. In the event of any complications, I will immediately contact the technician who performed the treatment.
_____ I understand that as a result of the treatment, I may experience some degree of discomfort. This can include but is not limited to stinging, mild swelling, redness, a hot feeling, or some tightness and dryness.
_____ I understand that I must refrain from any facial waxing for the next 72 hours (if having a peel).
_____I understand that I must refrain from tanning for 14 days following the end of the treatment. I also agree that should I be exposed to direct sun, I will use a broad spectrum UVA/UVB sunscreen with a minimum SPF of 15.
_____ I understand and agree that photographs will be taken before and after each procedure(s).

I have been candid in revealing any existing or new conditions(s) that I have. My technician has asked at this time whether I have any questions and I do not. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. I understand the procedure, risks, benefits and alternatives.

Client Signature _____ Date _____

Technician Initials _____ Date _____