

pelle — spa

Informed Consent for Dermaplaning

Full Name _____ Age _____ Date _____

Dermaplaning is an effective and safe exfoliation procedure. It uses a sterile blade to manually remove the surface of the skin effectively removing dead skin and vellous hair (peach fuzz) on the face. The blade is held at a 45 degree angle and is brushed along the skin to remove the hair and skin cells, painlessly exfoliating the skin to stimulate cellular turnover with little to no downtime. The procedure makes skin look and feel smoother and will reduces the appearance of fine lines and superficial skin discoloration. The hair is expected to grow back blunt ended. New hair will not appear darker of denser. However, any hormonal imbalance that may be present within my anatomical system can alter the normal hair growth pattern and cause a darker and denser restoration process. As with any procedure, some risks may be involved.

- Cuts or abrasions to the skin are unusual, but may occur
- Redness may persist anywhere from a few minutes to several hours.
- Pigmentation is rare and usually temporary. Possible permanent changes in the color of the skin could occur.
- Scarring is very unusual, but may occur.
- Infection is extremely unlikely, but may occur

My questions have been fully answered and I have read or have had read to me this document, have not taken any medications which may impair my mental ability, do not feel rushed or under pressure and understand its contents. I hereby give my unrestricted informed consent for the procedure.

I understand that cancellations must be made prior to appointments. I understand I must cancel 24 hours prior to my scheduled appointment or I will be charged \$25.00 for every missed appointment.

I give permission for photographs taken of all treated sites to be used for the medical record, and anonymously for teaching, illustration in scientific papers or for marketing and/or literature.

I agree to follow up at recommended intervals to assess my status and to inform Pelle Spa, LLC of any problems that I may be having and allow examination at that time.

I have been given and have read and understand the pre- and post-care instructions

I am aware that it is my responsibility to inform Pelle Spa providers of my current medical conditions. I agree to abide by the above policy statements. I understand that, as with any cosmetic procedure, individual results may vary and that NO refunds will be given. I understand that if I am dissatisfied with the results of the services rendered that I am not entitled to a refund. I understand that as a valued customer of Pelle Spa, that I may contact them to determine if there is a remedy for my dissatisfaction. If I choose not to allow Pelle Spa to remedy the issue, or if i choose to allow Pelle Spa to remedy and I am still dissatisfied, that I am not entitled to a refund. I

hereby release the technician performing the procedure, Pelle Laser Spa, LLC and Annette Randlemon, CNP from all liabilities associated with any and all of the above indicated procedures.

Signature

----- Date -----

Signature of Parent/Guardian (if patient is under 18)

----- Date -----

Provider Name and Signature

----- Date -----

*This consent is good for one year.