

VI Peel Consent Form

The VI Peel* contains a synergistic blend of powerful ingredients which are suitable for all Fitzpatrick skin types. VI Peels will improve the tone, texture, and clarity of the skin. It will reduce age spots, improve hyperpigmentation (including melasma), soften lines and wrinkles, clear acneic skin conditions, and reduce or eliminate acne scars.

Contraindications

- Patients who are pregnant or breastfeeding
- Patients who have an aspirin allergy or phenol allergy
- Patients who have used isotretinoin (Accutane*) within the past 3 months
- Patients who have active cold sores, warts, open wounds or history of herpes simplex
- Patients who are undergoing chemotherapy and/or radiation therapy
- Patients with a history of an autoimmune disease or any condition that may weaken their immune system
- Patients who have a liver condition

_____ Prior to receiving treatment, I have informed the practitioner of any conditions or medications that may contraindicate this statement.

_____ I understand that there may be some degree of discomfort such as burning, stinging, redness, heat or tightness during the procedure and for the following week.

_____ I understand that there is no guarantee regarding final results of the peel. Though uncommon, hyperpigmentation may develop, which may persist for weeks or months after the peel.

_____ I understand that although complications are very rare, sometimes they may occur. In the event of any complications, I will immediately contact the practitioner who performed the treatment.

_____ I understand that maintenance VI Peel* treatments are necessary to maintain results, as well as the recommended VI Derm* skin care regimen.

_____ I understand that extended direct sun exposure, including tanning beds, is strictly prohibited before and after receiving the VI Peel*.

_____ I understand that I must protect my skin with VI Derm SPF 50+ and avoid sun exposure during the exfoliation process.

_____ I understand that this is an elective cosmetic procedure and is non-refundable. I understand payment is my sole responsibility.

_____ I understand that no other chemical peels or medical device treatments may be performed on my skin until my physician/clinician releases me to do so.

_____ I understand that I must avoid strenuous exercise and heavy sweating, which will raise my skin temperature, for at least 72 hours following the peel.

Patient signature

Date

