MIDWEST INTEGRATIVE HEALTH LLC

MIH - Dermaplaning Consent Form

Dermaplaning Consent Form

I hereby authorize my practitioner to perform a Dermaplning Facial Treatment.

The following points have been discussed with me:

• The goal of a facial treatment, as in any cosmetic procedure, is an improvement, not perfection.

• We recommend a dermaplaning facial for all skin types and all ages.

• For optimal results, the use of daily at home skincare products prescribed by your provider is recommended.

• Extractions may be added to treatment to gently and safely remove blackheads, drain inflamed acne impactions, and release trapped ingrown hairs.

• If extractions are done wait 24 hours before applying acne and other active products, scrubs, astringents, lighteners, AHA/BHA, Retinol and/or other vitamin-A products.

• Dermaplaning Facials could cause temporary redness and/or purging of the pores.

• You should let your provider know if you are pregnant, have asthma, and/or sensitive areas.

Facial Treatment Includes:

• Deep Cleansing

• Mild Exfoliation

• May or May Not Include Steam

• Moisturizer

• SPF

I understand I am receiving an exfoliation treatment using a sterile surgical blade which removes most, not all vellus hair (peach fuzz) and as with the use of any sharp instrument, there is the possibility of nicks or cuts.

I understand the results of this treatment may vary due to conditions such as age, condition of skin, sun damage, climate, etc. and this treatment is a cosmetic treatment in which no medical claims are expressed or implied.

I have read and understood prior to the treatment the benefits and outcome of the service.

I understand with ANY beauty service there are inherited risks, including but not limited to allergic reactions. Understanding potential side effects may include, grazing, abrasions, skin sensitivity or adverse reactions to products used during treatment.

I understand I must follow my aftercare to prevent potential skin irritations and that direct sun exposure, including tanning beds, is not recommended while undergoing treatment and the use of a daily sun block protection is mandatory.

I understand there are contraindications to this treatment, including but not limited to, diabetes (not controlled by diet or medication), cancer, active acne, bleeding disorders, the inability for blood to coagulate or the development of keloids following injury. Certain medications including blood thinners, higher dosages of Aspirin, and Accutane are contraindicated for this treatment due to 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

I understand that not providing the required information regarding what I do before or after the treatment may affect the results, and do not hold the Midwest Integrative Health, LLC or any of its providers responsible.

Please check if you are using any of the following:

Please check if you suffer from any of the following:

I give my permission to photograph my face and these photos may be used in portfolios, as an expert witness, advertising, or for educational purposes without any present or future payment to me.

I am 18 years of age or older and have informed the provider of any physical or psychiatric health problems that would prevent me from having this procedure performed, and I know of no reason why I should not have these procedures performed on me. I understand that temporary redness, swelling, bruising and discomfort may occur from this procedure. Possible complications that could occur include, but are not limited to, risk of infection, allergy or sensitivity to local anesthetics and inconsistent results. I will also seek medical attention as recommended by the provider if necessary and understand that I am responsible for the full payment of expenses incurred in the event this is necessary.

This procedure is being performed under standard sanitizing and sterilizing methods as recommended by the Centers for Disease Control and as required by the State Department of Health. All scalpels or needles used of are disposed of properly after each procedure.In consideration of the provider providing me with the service requested, I for myself, my spouse, legal representatives, heirs, and assigns, hereby release, waive and discharge Midwest Integrative Health, LLC and its providers from liability for all loss of damage on account of or injury to person. I understand several procedures are necessary to achieve the desired effect and agree to complete my treatments as recommended. Should I not complete treatments, I will be responsible for any adverse outcome.I expressly agree that this consent, waiver, and indemnity agreement is intended to be as broad and inclusive as permitted by the laws in the State of Illinois. I have read this consent and understand all its terms and execute this release voluntarily, and with full knowledge of its significance. All my questions have been answered satisfactorily prior to signing of this consent.

Dermaplaning Facial has been thoroughly explained to me. I realize that no promises or guarantees have been made. I understand that the treatment may be repeated several times to achieve complete satisfaction. I understand that this treatment is voluntary on my part.

I understand that I am responsible for the fees associated with the service at the time of the appointment. I further understand that there are **NO** refunds for services rendered.

By signing this form, I acknowledge that I have read this form, that I fully understand its contents, and that I have been given ample opportunity to ask questions and that all questions have been answered to my satisfaction. I understand that I can call or return to the office at any time with questions or concerns.

I consent to allow the medical personnel to perform a facial treatment.

BY SIGNING BELOW, I ACKNOWLEDGE AND CERTIFY THAT I HAVE READ AND UNDERSTAND THE DERMAPLANING CONSENT AND TREATMENT FORM AT MIDWEST INTEGRATIVE HEALTH AND THAT I AM SIGNING THIS FORM VOLUNTARILY.

PLEASE SIGN YOUR FULL NAME BELOW IF YOU AGREE -

Date