DERMAPLANING CONSENT

I understand that dermaplaning involves the use of a surgical blade to remove fine vellus hair and dead layers of skin from the face.

The nature and purpose of this treatment has been explained to me and any questions I have regarding the treatment have been answered to my satisfaction.

I understand that the treatment may involve the risk of complication or injury and I freely assume those risks. Possible side effects of the treatment area can include mild redness of the skin, irritation, and dryness. Additionally, nicks to the skin can occur due to the sharp surgical blade. Patient will be notified and the area will be treated if necessary.

I certify that I have read this consent and I understand and agree to the information provided in this form. I certify that I am of at least 18 years of age. I agree and will adhere to all safety precautions and regulations during the skin treatment.

I have received and understand the post care recommendations as follows: no sun exposure for 48 hours and use of sunscreen (SPF 30 or higher) is highly recommended post-treatment for at least the next 7 days.

Patient
Signature:____Date:____________________

Witness:____Date:____________________

Aesthetician/Provider: _______________________________Date:____________________