LOW COUNTRY
DERMATOLOGY

SILK PEEL DERMALINFUSION PATIENT INFORMED CONSENT FORM

The Silk Peel system is a safe and highly effective treatment for simultaneous exfoliation of the skin with delivery of a topical formula to target a specific dermatological condition. Exfoliation promotes the reduction of fine lines, wrinkles, minor scars, acne, stretch marks, and sun damage. It also regenerates the epidermal cell structure resulting in skin elasticity and a more youthful, pliable, smooth skin. Topical formulas penetrate the skin to treat specific conditions such as acne, hyperpigmentation, photodamage, dehydration and fine lines, and wrinkles. The Silk Peel treatment performed with your practitioner's recommended pre and post treatment skin care regimen promotes optimal outcomes.

____ I acknowledge that I might experience a scratchy, stinging sensation during the treatment. This sensation will subside during the post treatment protocol.

____ I acknowledge that if I suffer from acne, the condition may temporarily look worse after the treatment, but will improve after additional treatments.

____ I understand if I fail to use sunscreen, I am more susceptible to sunburn and hyperpigmentation. Exercise should be limited after the treatment for 24 hours.

____ I acknowledge that I have not been on Accutane for acne therapy during the past six months. I acknowledge that I have not been using Retin-A for the past two weeks. I will discontinue the use of Retin-A for 1-3 days after therapy.

____ I acknowledge that facial telangiectasia (small blood vessels) is sometimes more apparent immediately after the treatment when the skin is thin and will diminish after re-epithelialization (build up of dead cells)

____ I agree to remove my contact lenses prior to the procedure (if applicable).

____ I acknowledge that if I am prone to cold sores (herpes) around the mouth or facial area, I may need a prescription for Zovirax from my medical doctor prior to having the treatment and avoid all treatments during breakouts.

____ I understand that my physician and / or the operator use tools that are either disinfected or disposable.

____ I acknowledge that my skin might experience temporary tightness, redness, or slight swelling which disappears in a few hours depending on my skin's sensitivity

____ The following physical or dermatological condition(s) apply to me:
__ pregnant or lactating __ rosacea __ salicylate or aspirin sensitivity __ none

I hereby agree to have the Silk Peel treatment performed on my skin and to follow all post treatment protocols.

_____ _____

Patient Signature Date