Ultrasonic Facial
Informed Consent Form

Please initial and sign/date below. This form is designed to help give you the information needed to make an informed decision to undergo treatment(s) with particle free dermabrasion system, or Ultra Sonic Facial (USF).

___ I understand the USF will be used to exfoliate and moisturize the skin on my face.

___ I understand my results may vary from results of other clients. I understand that due to the nature of the treatment, it may be necessary to undergo a series of treatments (a treatment program) to achieve satisfactory results.

___ I understand that to achieve maximum results, I should adhere to the program prescribed. The treatment schedule I have been given is designed to maximize the results. If for any reason the schedule cannot be adhered to, I understand the total result could be affected.

___ I understand the possible side effects and complications of the USF may include:

1. **Discomfort.** You may feel a slight amount of discomfort during treatment. This is very minimal and it will subside very soon after the treatment.
2. **Irritation.** You may encounter a slight amount of irritation following each treatment. This is very rare and is due to the degree of the exfoliation and product used on the skin.

___ I understand the following products are contraindicated with the USF:

1. **Accutane.** The use of Accutane is contraindicated with the USF. You must stop the use of the drug before the treatment of the USF for at least 12 months and cannot be used during the course of any USF treatment program.
2. **Chemical Peels. (TCA, ALA, Phenol, etc.)** The use of any chemical peel is contraindicated for thirty days before the USF treatment. You may use a chemical peel immediately after the USF, however.

___ I have/am (circle all that apply): a pacemaker / tumors / a thyroid condition / metallic implants / an infection / epilepsy /pregnant or lactating / palsy / an allergy to metal /thrombosis / phlebitis / cancerous lesions / a skin disease / diabetes /an acute medical condition /had a recent operation / scar tissue less than 12 weeks old / used retin-A / none of these conditions.

___ The specific treatment protocol chosen is the Ultrasonic Facial. The Esthetician has explained the theory and any risks/complications involved, its successes and benefits.

I hereby authorize,_____ to perform and/or assist in the Ultrasonic Facial treatment. I authorize the taking of any photographs in the course of the procedure for commercial and medical education purposes. I certify that I have read and fully understand the contents of this consent form before signing my name below.

I acknowledge I have received a copy of this informed consent form and signed the SKIN information forn. By signing below, I acknowledge I have read the foregoing informed consent form and I feel the operator has adequately informed me of the risks of this treatment and I hereby consent to treatment as described by:_____

Printed Name: _____ **Date:** _____

Signature:

milk + honey®

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