INTERLOCKS™
MEDSPA + WELLNESS

INFORMED CONSENT FOR DERMAPLANING

Patient Name: ____ Technician: _______________________________________

The goal of this treatment is the removal of superficial facial hair and superficial exfoliation. The procedure uses a dermaplaning blade / surgical scalpel, which is mildly abrasive. The total number of recommended treatments will vary between individuals to reach desired results.

The following problems may occur:

1. May get a scratch, nick, or cut.
2. May feel like razor burn.
3. Skin may be sensitive and/or irritated for a few days post-treatment.

Compliance with the aftercare guidelines is crucial for healing, prevention of scarring and hyperpigmentation. I acknowledge my obligation to follow the written and spoken instructions covering my pre and post treatment skin care regimen.

ACKNOWLEDGEMENT:

I acknowledge that the following points have been discussed with me:

- Potential results of the proposed procedure, including the possibility of no appreciable improvement
- Alternative treatments such as acid peels, laser skin resurfacing and treatments, or no treatment at all.
- Possible complications/risks involved with the proposed procedure and subsequent healing period

For women of childbearing age: By signing below, I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep Technician informed should I become pregnant during the course of treatment.

I hereby authorize above named Technician to perform light based hair reduction on me. I understand that this procedure uses a dermaplaning blade / surgical scalpel, which is mildly abrasive therefore I will follow the explicit instructions of my nurse or aesthetician. I understand that my nurse or aesthetician may discover other conditions that require different procedures, at which time alternate recommendations for additional treatments may be made. I understand that with any treatment certain risks are involved, and that any complications or side effect from known or unknown causes may occur. I freely assume these risks. I agree to all safety precautions and home skin care program as recommended by my nurse or aesthetician. My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release INTERLOCKS from all liabilities associated with the above indicated procedure.

Patient/Guardian Printed Name: ____ Date: _____ /_____ /_____

Patient/Guardian Signature: ____ Date: _____ /_____ /_____

Nurse/Aesthetician Signature: ____ Date: _____ /_____ /_____