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**CONSENT FOR CHEMICAL PEEL (Page 1 of 2)**

\_\_\_\_ Patient's Name \_\_\_\_\_ Chart # \_\_\_\_\_ Date \_\_\_\_\_

I have been informed that I have the following condition(s): \_\_\_\_\_

The procedure(s) to treat my condition(s) has/have been describes as: \_\_\_\_\_

**Please initial each paragraph after reading. If you have any questions, please ask your doctor before initialing.**

**I HAVE BEEN TOLD AND I UNDERSTAND THAT:**

- \_\_\_\_\_ 1. Chemical peel is a process by which certain chemicals are applied to the skin in an attempt to improve the appearance of lines, wrinkles, skin blemishes and certain other localized cosmetic skin conditions.
- \_\_\_\_\_ 2. During the peeling process I will experience some discomfort and swelling, and the treated area will be covered with a crust, which will usually separate within one or two weeks.
- \_\_\_\_\_ 3. My skin may have a reddish appearance which may persist for several weeks or longer, and that at the junction of treated and untreated areas there may be a different color or blotching of the pigmentation and changed texture of the skin may persist.
- \_\_\_\_\_ 4. Scarring can occur which may result in permanent disfigurement.
- \_\_\_\_\_ 5. Chemical peel will not stop the aging process, and that further treatment may be necessary, depending upon aesthetic and cosmetic conditions.
- \_\_\_\_\_ 6. Hyperpigmentation (the color of the treated areas becomes darker than the surrounding skin) is a possible side effect. Certain medications may be prescribed or recommended to help minimize this effect. Hypopigmentation (lightening of the skin color) is a rare complication. Both of these pigment complications usually fade in 6-12 months; however, they may be permanent. Please inform your doctor if you have used Accutane within the past year, or if you have ever had cold sores or other blister lesions on your face.
- \_\_\_\_\_ 7. No guarantee or assurance has been given to me that the proposed treatment will be curative and/or successful to my complete satisfaction. I understand it's impossible to predict someone's result, "for instance looking 10 years younger." Due to individual patient differences, there is a risk of

failure or relapse, my condition may worsen, and selective re-treatment may be required in spite of the care provided.

- \_\_\_\_ 8. I have had an opportunity to discuss my past medical and social history, including drug and alcohol use, with my doctor and have provided full information. I recognize that withholding information may jeopardize the planned goals of surgery.
- \_\_\_\_ 9. I agree to cooperate fully with my doctor's recommendations while under treatment, realizing that my lack of cooperation can result in less than optimal result.

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- \_\_\_\_ 10. If any unforeseen condition should arise during surgery that may call for additional or different treatment from that planned, I authorize my doctor to use surgical judgment to provide appropriate care.
- \_\_\_\_ 11. Every precaution will be taken to ensure that the chemical solution does not penetrate inside the eye. However, if this happens, further treatment and follow-up will be necessary. Blurred vision and blindness may occur.
- \_\_\_\_ 12. Revision surgery, although rare, is a possibility with any cosmetic procedure. Post operative touch Ups are usually minor and most often performed with local anesthesia. A surgical fee will be Charged commensurate with the extent of the revision.

**FEMALE PATIENTS**

- \_\_\_\_ 1. I have informed my doctor about my use of birth control pills. I have been advised that antibiotics and other medications may neutralize the preventive effect of birth control pills, allowing for conception and pregnancy. I agree to consult with my physician to initiate additional forms of birth control during the period of my treatment, and to continue those methods until advised by my physician that I can return to the use of birth control pills.

**CONSENT**

I certify that I have had the opportunity to fully read this consent, and that all blanks were filled in before my signing. I also certify that I read, speak and write English. My signature indicates my understanding of my proposed treatment and I hereby give my willing consent to the surgery.

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Patient's (or Legal Guardian's) Signature

Date

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Witness' Signature

Date

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Doctor's Signature

Date