



CONSENT FOR CHEMICAL PEEL

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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. Other: _____

- _____ 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.
- ____ 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.

Patient’s (or Legal Guardian’s) Signature

Date

Witness’ Signature

Date

Doctor’s Signature

Date