Le Mieux

RENEW. REGENERATE. REVIVE

PATIENT CONSENT AGREEMENT

Date	Initials	
		Prior to receiving treatment, I have revealed any condition that may have bearing on this procedure.
		I understand that there will be discomfort such as stinging, a prickling sensation, tightness or heat.
		I understand that there are no guarantees as to the results of this treatment.
		I understand that every procedure provides different results.
		I understand that the extent of peeling does not correlate with the degree of improvement.
		I understand that this treatment is a cosmetic procedure.
		I understand that as a cosmetic procedure, there are no medical claims expressed or implied with this treatment.
		I understand that to achieve maximum results, I may need multiple treatments.
		I understand that complications may occur.
		I understand that complications require prompt treatment when necessary. In the event of any complications, I will immediately contact my physician/clinician who performed the treatment.
		I agree to avoid tanning, tanning beds, and being exposed to the outdoor for an elongated period of time during the 14 days prior to and after the treatment.
		I understand that extended periods in direct sun exposure is prohibited while I am undergoing the treatment.
		I agree to use sun protection with a minimum of SPF 15 on a daily basis.
		I have not received any other chemical peel procedures of any kind within 14 days of this treatment.
		I understand that I cannot receive another chemical peel procedure within 14 days of this current treatment, whether it is performed at this location or any other location.
		I understand that I should follow my clinician's recommendations for post-procedure care to minimize side effects and maximize my results.

I hereby agree to all of the above and agree to have this treatment performed on me by this clinician. I further agree to follow all post-procedure care instructions as I am directed by my clinician.

Your Signature: X_____ **Print Name:** _____ **Date:** _____

OFFICE USE ONLY

Clinician Signature: X_____ **Print Name:** _____ **Date:** _____

Witness Signature: X_____ **Print Name:** _____ **Date:** _____