AUTHORISED TREATMENT PROVIDER INFORMED CONSENT FORM: ÜBER PEELING

I,_____authorise _____
of (Business Name)_____to perform the treatment(s):

Dp Dermaceuticals **ÜBER peel**

I acknowledge that no guarantee has been made about the results of the procedure. Although it is impossible to list every potential risk and complication, I have been informed of the possible risks and complications, which may include, but are not limited to, the following:

- stinging, itching, irritation
- redness and swelling of the skin
- tightness, peeling or scabbing of treated skin and the surrounding areas
- prolonged skin sensitivity to wind and such environmental elements
- period of possible dryness, itchy or irritation; my skin may appear older during the phase of skin renewal.

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I certify that I am over the age of eighteen (18) and that:

- In the last 12 months I have not used Accutane, isotretinoin (or its generic form) or received chemotherapy or radiation therapy.
- I am not pregnant or breastfeeding.
- I do not have a history of radiation to the treated area.
- I do not have active herpes simplex or active infection.
- I do not have a history of keloid scar formation.
- I have not waxed in the past fortnight or shaved the treated area for 24 hours.
- I have not used Retin A, benzoyl peroxide or similar medications for 2 weeks.
- I WILL protect my skin from direct sun for 3 days post procedure.
- I WILL use a broad-spectrum sunblock every day (such as Dp Dermaceuticals **COVER RECOVER**) and reapply when necessary.
- I WILL avoid hot baths/showers, sweating and strenuous exercise for 3–5 days post procedure.
- I WILL avoid rubbing, picking and scrubbing my skin post procedure, for I understand it could lead to scarring.
- I WILL NOT use retinoids or other exfoliating agents until my skin is healed.

I have read and will follow to the best of my ability any and all instructions. I understand the potential risks and complications and choose to proceed after careful consideration of the possibility of both known and unknown risks, complications, limitations, and alternatives.

Patient's signature _____ Date _____

Treatment Provider's signature _____ Date _____