



V.I. Peel Consent

I authorize the chemical peel listed above, to my face and / or neck, chest and hands.

I understand that:

- Depending on the chemical peel site, there may be redness and/or irritation and discoloration (dark tan and pink marks) that can persist for several days or weeks.
- Occasionally hyper pigmentation or hypo pigmentation might develop after the peel that might persist for weeks or months.
- With each chemical peel results are achieved. Nevertheless, no guarantees can be made as to the final results. Any number of chemical peels may be required to achieve desired results, depending on the present skin condition, skin care maintenance program, age and lifestyle of the patient.
- Once the desired results are achieved, I understand that maintenance peels are necessary to sustain the rejuvenated results. The frequency depends on the individual's own genetics, age and lifestyle.
- Once peeling process is complete it is essential to follow instructions and/or use the V.I. Derm skin care line, or other, to maintain results and avoid any future complications especially hyper pigmentation.
- I understand that this peel is made of the strongest acids such as Phenol and Trichloroacetic acid, also referred to as TCA, salicylic acid, among others. The exact composition is proprietary information of the V.I. Peel system, and I waive any rights, present or future, I may have as to request to divulge the exact composition or concentrations.
- Services are cosmetic in nature, and are non-refundable. I understand that payment is my sole responsibility.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read and fully understand the above paragraphs and that I have had sufficient opportunity for discussion and to ask questions.

BY SIGNING BELOW, I ACKNOWLEDGE AND CERTIFY THAT I, _____, HAVE READ AND UNDERSTAND THE "CONSENT, RELEASE AND INDEMNITY AGREEMENT" FOR THIS PROCEDURE, AND THAT I AM SIGNING IT VOLUNTARILY.

PLEASE SIGN YOUR FULL NAME BELOW IF YOU AGREE.

Patient Signature & Date