CONSENT FORM
Glytone Glycolic/Salicylic Acid Treatment

I, ________________________, authorize Westmoreland Dermatology to perform Glytone Glycolic or Salicylic Acid Treatments for the purposes of deep cleansing, acne, pigmented abnormalities, minor wrinkles, and to give a generally more glowing appearance to the skin.

INTRODUCTION: Chemical Peels are treatments that are intended to improve the appearance of the skin. The treatment uses multiple levels of Glycolic or Salicylic Acid.

HOW IT IS PERFORMED: The face will be cleansed with a pre-procedure cleansing wipe, and then a solution will be wiped across the area to be treated. The peel will then be neutralized.

HOW MANY TREATMENTS ARE RECOMMENDED? This treatment can be performed as often as every two weeks, but it is recommended that you have one treatment every 4-6 weeks.

ARE THERE ANY SIDE-EFFECTS? I understand that most patients experience no adverse side effects whatsoever. Possible side effects may range from ultra-mild swelling, redness, mild scabbing to mild peeling; all of which are temporary. At most, side effects last a few days and may be treated by avoiding cosmetic products and medications for a few days. The procedure may cause my skin to appear red and peel like a sunburn. During and after the procedure, the following may be experienced: stinging, itching, burning, mild pain, tightness, peeling and scabbing of the superficial layers of the skin. These sensations will gradually diminish over the course of the week as the skin returns to its normal appearance. However, some patients may react differently. **I will contact my physician immediately if any of the side effects occur or persist.**

I must not and have not used Accutane (or similar product) for six months prior to receiving this treatment. I must not and have not used Retin-A, Tretinoin, Tazorac, Differin, Hydroquinone, Glytone products or any other retinoids three to five days prior to the chemical peel. This treatment must not be performed if is there is skin irritation, eczema, inflammation or dermatitis. I must not and have not used tanning beds or been exposed to the sun two weeks prior to treatment. I must not and have not waxed, had electrolysis treatments or had laser hair removal treatments within the past five days.

I have also made the office aware of any allergies that that I may have that may interfere with the efficacy of the treatment.

NOTE: THIS LIST MAY NOT BE INCLUSIVE OF ALL POSSIBLE RISKS AND SIDE EFFECTS ASSOCIATED WITH CHEMICAL PEELS.

LIMITATIONS: Most patients are pleased with the results of Chemical Peel treatments. However, like any cosmetic procedure, there is no guarantee that you will be satisfied. There is no guarantee that the abnormal skin areas will disappear, or that you will not require additional or alternative treatments to achieve the results you seek. In addition:

1) Chemical Peels will not remove hair.
2) Chemical Peels can improve pigmented sun-spots and the general texture of the skin.
3) Chemical Peels may significantly help active acne lesions.
4) Fine wrinkles may be improved, but some of the more prominent and defined wrinkles will require other approaches.
5) Some improvements in scars may occur, but deep scars may require other approaches.

NO GUARANTEE HAS BEEN GIVEN BY ANYONE AS TO THE RESULTS THAY MAY BE OBTAINED BY THIS TREATMENT

RESTRICTIONS: I agree to follow all aftercare instructions provided to me.

ALTERNATIVE THERAPIES: This is strictly a voluntary cosmetic procedure. No treatment is necessary or required. Other alternative treatments which vary in sensitivity, effect and duration may include mid-level chemical peels, laser treatment, etc.

I HEREBY ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND ALL OF THE INFORMATION PRESENTED TO ME BEFORE SIGNING THIS CONSENT, THAT THE BENEFITS AND RISKS, AS WELL AS THE ALTERNATIVES, TO THE ABOVE PROCEDURE HAVE BEEN FULLY EXPLAINED TO ME, AND ALL THE QUESTIONS THAT I MIGHT HAVE ABOUT THE PROCEDURE HAVE BEEN ANSWERED IN A SATISFACTORY MANNER. I HEREBY GIVE UNRESTRICTED INFORMED CONSENT TO UNDERGO THE PROCEDURE. I UNDERSTAND THAT THIS SERVICE GENERALLY CONSIST OF A SERIES OF TREATMENTS AND SERVICES TO ACHIEVE MAXIMUM BENEFIT, AND THIS CONSENT SHALL APPLY TO ALL FUTURE TREATMENTS OF THIS SERVICE TO ME, INCLUDING ONGOING OR INTERMITTENT TREATMENTS.

I UNDERSTAND THAT THIS IS A COSMETIC PROCEDURE THAT IS NOT COVERED BY MY INSURANCE COMPANY, AND I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR THIS TREATMENT AND ALL SUBSEQUENT TREATMENTS. WE ACCEPT CASH, CHECKS, DEBIT CARDS AND ALL MAJOR CREDIT CARDS.

Patient Signature: ______________________________ Date: ______________

Parent Signature (if patient is under 18): ______________________ Date: ______________

Patient Signature: ______________________________ Date: ______________

Patient Signature: ______________________________ Date: ______________

Patient Signature: ______________________________ Date: ______________

Patient Signature: ______________________________ Date: ______________

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