Patient Consent

Alumier MD

FULL DISCLOSURE:

Prior to receiving treatment, I have reviewed and signed the Patient Profile given to me by my physician/skin care professional. I have been truthful in disclosing information that may have bearing on this procedure including the following:

- **ACCUTANE USE** (if so do not do treatment) • **PREGNANCY** (if so do not do treatment)
- **NURSING/LACTATING** • **HISTORY OF COLD SORES** • **ALLERGIES** • **ASPIRIN ALLERGY**

POSSIBLE ADVERSE EVENTS:

I have been informed that the following may occur post treatment:

- Hyperpigmentation/hypopigmentation (to minimise this, the proper post procedure must be followed)
- Allergic Reaction: I also understand that exposure to different ingredients found in the treatment and associated home care products may result in an allergic reaction. If an allergic reaction occurs, I will immediately discontinue use of all professional treatments and AlumierMD home care products and consult my physician
- Contact dermatitis, inflammation (redness), edema (swelling), skin irritation (itchiness)
- Temporary sensation of heat and itchiness immediately following treatment

PEELING:

I understand that I may or may not actually peel and that each treatment is individual. I understand that the degree of peeling does not correlate with the degree of improvement.

CONDITIONS OF TREATMENT:

I agree to refrain from the following activities for 14 days post treatment:

- Sun or tanning bed exposure • Microdermabrasion • Laser hair removal • Photofacials • Chemical peels • Laser / RF skin treatments

I agree to refrain from the following activities for 7 days post treatment:

- Waxing, threading, and all use of other depilatories • Neurotoxin injections (eg. Botox, Dysport)
- Dermal filler injections • Use of retinoids • Use of mechanical exfoliants
- Use of topical AHA/BHA and all other exfoliant topical skin care products
- Use of sunless tanning products • Acne topical treatments

I agree to disclose the names of all prescription and non-prescription products that I am using.

I agree to follow all post-procedure protocols recommended by my physician/skin care professional.

I agree to use a professional, medical grade sun protection product (SPF 30 or higher) for a minimum of 14 days post treatment.

LIMITATIONS TO TREATMENT:

I understand there are no guarantees as to the results of this treatment due to many variables including age, skin condition, sun damage, smoking, climate, etc. I understand that this treatment is cosmetic and that no medical claims are expressed or implied. I understand that to achieve maximum results, I may require several treatments.

COMPLICATIONS:

I understand that although complications are rare, they do occur and prompt treatment is necessary. In the event of a complication, I will contact the physician/skin care professional who performed my treatment. I hereby certify that all the information that I have provided has been accurate and truthful. I acknowledge the above adverse events, limitations and complications. I further acknowledge that these adverse events, conditions, limitations and complications have been explained and that I accept and consent to treatment. I agree to follow all post treatment care instructions provided to me. I acknowledge that I have been provided with adequate time to read, understand and accept the above adverse events, limitations and complications.

TREATMENT LOG

DATE	INITAL

Patient Signature: _____ Date: _____