Facial Treatment Consent

Patient Name	:	sai krishna				Emirates ID	:	784-8666-6666666-7
File No	:	8	DOB	:	1996-09-25	Nationality	:	Other
Gender	:	Male	Doctor's Name	:	test test	Date	:	2024-04-11

The Treatment

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Skin Condition

☐ SUPERFICIAL ☐ WRINKLES ☐ FINELINES

☐ ROSACEA ☐ ACNEORACNEPRONE

☐ DEHYDRATION ☐ HYPERPIGMENTATION ☐ ACNESCARS

Precautions

The Treatment you will receive is a clinical treatment designed to exfoliate or remove the outer layers of the skin.

Your participation in your skin care treatments will determine the outcome. It is important that you strictly adhere to your home care products that your esthetician has recommended.

No guarantee is expressed or implied as to the precise results, peeling times or discomfort.

Depending on the treatment, you may experience some temporary stinging or warm flushing. During the next few hours, you may experience some tightening of the skin, which may last for several days.

For most patients, flaking begins within 48 hours. It is impossible to pre-determine how much peeling will occur. The shedÂ¬ding process usually subsides within 2-3 days.

Please Initial

☐ I AM NOT PREGNANT.

☐ I AM NOT ALLERGIC TO ASPIRIN.

☐ I AGREE TO AVOID DIRECT SUN EXPOSURE FOR 48 HOURS.

☐ I HAVE NOT USED RETIN-A FOR 72 HRS.

☐ I AGREE TO NOTIFY MY ESTHETICIAN OF ANY CONCERNS.

☐ I DO NOT HAVE ACTIVE COLD SORES.

☐ I AGREE TO APPLY SUNSCREEN DAILY.

☐ I HAVE NOT TAKEN ACCUTANE IN THE PAST YEAR.

☐ I AGREE NOT TO WAX FOR 72 HOURS PRE/POST TREATMENT.

☐ I AGREE TO NOT LASER FOR 2 WEEKS.

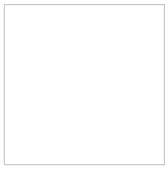
☐ I AGREE TO NOT PICK OR PULL AT THE SKIN AFTER THE TREATMENT.

☐ I WILL NOT HAVE ANY OTHER FACIAL PROCEDURE.

☐ POSSIBLE SIDE EFFECTS INCLUDE: REDNESS, IRRITATION, FOR AT LEAST ONE WEEK AFTER TREATMENT. LOCAL SWELLING, MILD DISCOMFORT OR TENDERNESS, PIMPLE-LIKE BUMPS, DRY SKIN, LIGHTENING OR DARKENING OF THE SKIN, INFECTION, SCARRING, PEELING, AND ACTIVATION OF COLD SORES.

I hereby give my consent and authorization voluntarily and release Â [lbl_clinic]Â from any claims, implied or stated that I have or may have in the future with this treatment regardless of result. I am stating that the treatment and precautions above have been explained to me in detail and that I fully understand.

Sign here, only if all of your questions have been answered to your satisfaction	
PATIENT	DOCTOR

	
Patient Name sai krishna Date 2024-04-11	Doctor Name test test - Laser (1) Date 2024-04-11