



Consent for DERMAPLANING

Thank you for choosing Alazzo Med Spa, LLC. This form is exclusively related to Dermaplaning for skin rejuvenation. Please read this form thoroughly and ask any questions that you may have prior to treatment. This consent will serve for all Dermaplaning treatments performed and does not need to be renewed. Sign only after you feel comfortable enough to get started.

Procedure: I consent to have the Dermaplaning. My procedure will be performed by a state licenses esthetician under the supervision of a nurse practitioner. Demaplaning can remove fine facial hair (vellus hair), reduce fine lines and wrinkles, stimulate collagen and creates an overall more healthy skin appearance.

Dermaplaning Operation: The Demaplaning process uses a blade to remove or exfoliate the top few layers of dead skin cells as well as the vellus hair. During this process the body produces new skin cells to replace the ones lost resulting in a smoother more even skin texture. This procedure is non invasion and requires no down time. Treatments are recommended to be performed every 4 weeks to maintain results.

Restrictions: Your medical history will be reviewed at the time of treatment and discussed with you. Results cannot be guaranteed.

Standard Skin Effects: This is typically a painless procedure. It can be described as a cat's lick. After the procedure the skin may have a slight red or pink appearance and a "fresh" smooth feel. Redness may occur. This should resolve in the a few hours to a few days. If you are prone to herpes simplex such as cold sores this procedure may cause an outbreak. Prophylactic antiviral therapy can help with this. The top few layers of dead skin cells have been removed so it is important to protect this area from the elements. Avoid sun tanning or use tanning lotions is the area at least 2 weeks before and after treatments. A daily use of SPF of 30 or greater is necessary. Other procedures, such as laser hair removal or IPL that involve the area that have had Dermaplaning should be avoided for a week.

Pre and Post Instructions: I agree that I have received the pre and post treatment instructions and I will follow those instructions carefully. I acknowledge that failure to follow these instructions may result in an increased risk of complications or a reduction in optimal results.

I am at least 18 years of age and my signature below attests that I have all of my questions answered to my satisfaction, I am comfortable with the information received in this consent and I agree to the terms outlined in this consent.

Patient Signature _____

Provider Signature _____

If you have any questions after reading these guidelines, please do not hesitate to call us for clarification.