CONSENT FORM FOR CHEMICAL PEEL PROCEDURE

Clinic Name: _____ **Date:** _____
Doctor Name: _____
Patient Name: _____

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1. **PROCEDURE DESCRIPTION:**
   I, the undersigned, voluntarily consent to undergo a **Chemical Peel**. The procedure involves applying a chemical solution to exfoliate the skin, improve its texture, and reduce the appearance of fine lines, acne scars, and pigmentation

2. **POTENTIAL RISKS & COMPLICATIONS:**
   I understand that while Chemical Peels are generally safe, they carry potential risks, including but not limited to:

   - Redness, irritation, swelling, or burning sensation
   - Peeling, dryness, or crusting of the skin
   - Temporary or permanent hyperpigmentation or hypopigmentation
   - Increased sensitivity to sunlight
   - Infection or scarring (rare)
   - Allergic reaction to the peeling agent

3. **CONTRAINDICATIONS:**
   I confirm that I have disclosed any medical conditions that may affect the outcome of the procedure, including but not limited to:
   - Active skin infections, open wounds, or cold sores
   - Pregnancy or breastfeeding
   - History of keloid scars
   - Recent use of Accutane or other strong medications

4. **ALTERNATIVE TREATMENTS:**
   I have been informed of alternative skin rejuvenation treatments and understand that I have the option to decline treatment.

5. **POST-PROCEDURE CARE & FOLLOW-UP:**
   I understand that proper aftercare is essential and agree to:
   - Avoid sun exposure and use a broad-spectrum sunscreen daily
   - Refrain from picking or scratching the treated area
   - Follow the post-procedure skincare regimen as instructed by my doctor

6. **CONSENT TO PHOTOGRAPHY (Optional):**
   I give permission for my photographs to be taken for medical records and treatment monitoring purposes. These images will remain confidential.
   [ ] Yes, I consent

[ ] No, I do not consent

7. **INFORMED CONSENT & ACKNOWLEDGEMENT:**
   I have read and fully understand the information provided in this consent form. I have had the opportunity to ask questions, which have been answered to my satisfaction. By signing below, I acknowledge that I am making an informed decision to undergo this procedure.

Patient Signature: _____ **Doctor Signature:** _____

Date: _____ **Date:** _____

Witness (if applicable): _____

Date: _____