NEW LOOK
HOUSTON

Dermaplaning Consent

I understand that Dermaplaning involves the use of surgical blade to remove fine vellus hair and dead layers of skin from the face.

The nature and purpose of this treatment has been explained to me and any questions I have regarding the treatment have been answered to my satisfaction.

I understand that the treatment may involve the risk of complication or injury and I freely assume those risks. Possible side effects of the treatment area can include mild redness of the skin, irritation and dryness. Additionally, nicks to the skin can occur due to the sharp surgical blade. Patient will be notified and the area will be treated if necessary. The hair is expected to grow back blunt-ended. New hair will not appear darker or denser. However, I do understand that any hormonal imbalance that may be present within my anatomical system can alter normal hair growth pattern.

If a chemical peel is part of this treatment I understand that the sensation and penetration of the peel will be enhanced. Which may cause skin irritation, mild discomfort, and tenderness, lightening or darkening of the skin, infection, scarring, peeling, and activation of cold sores? I certify that I have read this entire consent and that I understand and agree to the information provided in this form.

I certify that I am competent adult of at least 18 years of age, or that, if I am a minor under the age of 18, I understand that the consent of my parent/guardian having legal custody will also be required before treatment. I agree and adhere to all safety precautions and regulations during the skin treatment.

I have received and understand the post care recommendations as follows: no sun exposure for 48 hours, moisturize as needed, use gentle cleanser only, Alpha and Beta Hydroxy acid (if desired) may be resumed 48 hours after treatment. Use of sunscreen is highly recommended post-treatment for at least the next 7 days. (SPF 30)

Patient Signature _____

Patient Name _____

Date _____

NEW LOOK
HOUSTON

Testimonial, Photo & Video Release

Please initial any or all of the following that apply:

_____ I agree to allow my treatment photos, testimonials, and/or videos to be used for promotional purposes. I understand that my name and identifying information will **NOT** be used.

_____ I agree to allow **ONLY** my first name, last initial and occupation to be attached to my treatment photos, testimonials, and/or videos for promotional purposes.

_____ I DO NOT agree to allow the use of my treatment photos, testimonials, and/or videos for promotional purposes.

This agreement supersedes any previous agreement you have with New Look Aesthetics regarding testimonial, photo and/or video usage.

SIGNED: _____ Date: _____

Print Name: _____

Written Testimonial About Your Experience at New Look Aesthetics