PERFECT APPEARANCE
DERMAFILE™

Informed Consent for Dermafile Exfoliation Treatment(s)

I,_____ authorize Skin Therapists at Spatique Skin Care to perform the Dermafile exfoliation treatment(s)

_____ I acknowledge that no guarantee has been made about the results of the procedure. Although it is impossible to list every potential risk and complication, I have been informed of some possible benefits, risks and complications which may include, but are not limited to, the following:

- Provides a smoother appearance of the skin
- Improves the appearance of fine lines and wrinkles
- Helps to even the coloring and lighten the pigmentation
- Supports the natural collagen syntheses in the skin
- Helps to build collagen and thicken the dermis
- Firms and tightens the skin
- Reduces scaring and acne lesions
- Skin may feel wind burned or sensitive for a few days
- May experience tightness and peeling of the skin

_____ I attest that I have had an opportunity to ask questions and have questions answered to my satisfaction.

_____ I am over the age of eighteen, and have discussed any skin conditions or diseases, infection or cold sores with my Skin Therapist or Physician and understand that this procedure could result in a flare-up of these conditions.

_____ I give my permission for photographs to be taken to record my progress.

_____ These photos may be used for teaching or marketing purposes. If photos are used for these reasons, my eyes will be covered to conceal my identity.

_____ I agree to follow post treatment instructions.

Client Signature:_____ Date: _____

Skin Therapist Signature:_____ Date: _____