PARTINGTON
PLASTIC SURGERY CENTER

AUTHORIZATION AND CONSENT FOR CHEMICAL PEEL or MECHANICAL PEEL

PLEASE READ THIS AUTHORIZATION CAREFULLY AND ACKNOWLEDGE YOUR UNDERSTANDING BY SIGNING YOUR NAME IN THE SPACE BELOW.

To The Patient. You have the right, as a patient, to be informed about your condition and the procedure to be used, indicating risks and benefits, so that you may make the decision whether or not to undergo the procedure. This authorization and consent form is an effort to make you better informed. To that end, we encourage you to ask our staff any questions you may have. You are also encouraged to conduct your own research or consult with your own health care provider if you have additional questions.

Procedure: Chemical Peel This procedure includes washing the face with cleanser then wiping off all excess oils with rubbing alcohol, acetone or another preparatory solution. The peel is then applied using pads or a brush and left on for the predetermined amount of time and then removed or, in some cases, the peel solution is not removed by the Technician. Follow up steps, such as additional cleansing and application of serums or creams may be taken depending on the peel used.

Procedure: Mechanical Peel This procedure includes washing the face with cleanser then wiping off all excess oils with rubbing alcohol, acetone or another preparatory solution. The skin is then patted dry and then either a microdermabrasion machine or a special blade is used to remove dead cells from the epidermis. Follow up steps, such as additional cleansing and application of serums or creams may be taken depending on the peel used.

Possible Side Effects: I understand that this procedure may cause side effects. The side effects listed here are merely examples and are not intended to be an exhaustive list. Every person is different and there is no guarantee that more severe side effects will not occur. Of the observed side effects, the most common are listed. Swelling of the face and/or treated area may occur. The epidermis may turn red (resembling sunburn) blister and/or crust before it heals. While unlikely: scarring, irregularities, abrasions, cuts and burns may occur as well. The peeling is usually one day to one week, but may vary depending on the individual. Mechanical peels sometimes do not involve any visible peeling. There may be a potential risk of developing pigmentation changes in the area treated, which may be temporary. Some patients have an allergic reaction to the peel or creams applied afterward which, in extremely rare cases, may lead to scarring. There may be some degree of discomfort during and after the procedure (stinging, pinpricking sensation, hotness and tightness).

How To Achieve Optimal Results. For the best results, I understand that multiple treatments will be necessary at additional cost.

Patient Questionnaire. By my signature below, I certify that the answers given herein are true and complete to the best of my knowledge.

Are you pregnant? [ ] Yes [ ] No
Are you trying to become pregnant? [ ] Yes [ ] No
Have you had any type of facial surgery within the past sixty (60) days? [ ] Yes [ ] No
If yes, state the type of facial surgery and the date: _____
_____
Do you have any allergies? [ ] Yes [ ] No
If yes, please list: _____
Do you have a tendancy to develop cold sores or fever blisters? [ ] Yes [ ] No
Have you had any type of peel treatment of this nature within the last 14 days? [ ] Yes [ ] No
Are you taking Retin A, accutane, or hormones, including birth control pills? [ ] Yes [ ] No
If yes, please list: _____

Authorization. I hereby authorize Partington Plastic Surgery Center, its employees, and agents to perform a superficial chemical peel procedure on me. I fully understand this procedure has limited applications. I am aware the practice of medicine and surgery is not an exact science and I acknowledge reputable practitioners cannot properly guarantee quality and/or results or freedom from complications, and I have not received such guarantees. I acknowledge I have had the opportunity to ask questions, and I fully understand the treatment of the chemical peel procedure. The procedure is generally considered cosmetic, and may not be covered by insurance. I understand I am responsible for all costs of the procedure and related treatments.

Waiver. I understand and acknowledge there are risks involved with the treatment of the chemical peel procedure, including, but not limited to, those side effects listed above. I have had the opportunity to ask questions regarding these risks and other possible complications. I understand any false or misleading information I have given may lead to undesired results and complications and hereby waive Partington Plastic Surgery Center liability if such results or complications occur. I further understand my failure to follow post care instructions may also lead to undesired results, complications or effects and hereby waive Partington Plastic Surgery Center liability if such results or complications occur. In consideration for Partington Plastic Surgery Center performing this procedure, I agree I will assume the risk and full responsibility for any and all injuries, losses, or damages, which might occur to me while I am undergoing this procedure or side effects I may experience after the procedure is performed. To the maximum extent allowed by law, I agree to waive and release any and all present and future claims, suits or related causes of action against Partington Plastic Surgery Center, its owners, officers, employees, or agents for negligence, injury, loss, death, costs or other injuries or damages to me as a result of this procedure. I agree this waiver and release shall bind the members of my family and any spouse or domestic partner, if I am alive, as well as my estate, family, heirs, administrators, personal representatives or assigns if I am deceased, and shall be deemed as a "Release, Waiver, Discharge and Covenant" not to sue Partington Plastic Surgery Center.

MAXIMUM LIABILITY. PARTINGTON'S PLASTIC SURGERY CENTER'S MAXIMUM AGGREGATE LIABILITY TO PATIENT RELATED TO OR IN CONNECTION WITH THE PROCEDURE PERFORMED BY PARTINGTON PLASTIC SURGERY, ITS EMPLOYEES, OR AGENTS WILL BE LIMITED TO THE TOTAL AMOUNT PAID TO PARTINGTON PLASTIC SURGERY CENTER BY PATIENT FOR THE PROCEDURE DESCRIBED IN THIS AUTHORIZATION AND CONSENT.

I certify that I have read and fully understand the above paragraphs, that I have had sufficient opportunity for discussion and to ask questions, and that I hereby consent to the procedure described above. I understand I cannot have another treatment of this kind performed within 14 days of the last treatment, regardless of where the treatment might be administered.

_____

Patient Signature Printed Name Date

_____

Signature of Parent/Guardian (if under 18) Printed Name Date

_____

Witness Signature Printed Name Date

I hereby authorize Partington Plastic Surgery Center to photograph or permit other persons to photograph me before, during and after this procedure. I agree that Partington Plastic Surgery may use and permit other persons to use the negatives, tapes or prints prepared from such photographs for such purposes and in such manner, as they may deem appropriate. I agree the photographs may be used for purposes, including, but not limited to, dissemination to physicians, health professionals, and members of the public for educational, treatment, research and advertisement and recruitment of prospective patients, that such dissemination may be accomplished in any manner, and that such use is subject only to the limitation that the patient's name will not be revealed. I understand that I will not be provided with any type compensation or discount if Partington Plastic Surgery Center uses the negatives, tapes or prints prepared from such photographs.

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Patient Signature Printed Name Date