KAROL A GUTOWSKI, MD, FACS
AESTHETIC SURGERY
CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY
MEMBER AMERICAN SOCIETY OF PLASTIC SURGEONS

CONSENT for CHEMICAL PEEL

Patient Name: Date:

Skin Conditions (Please select one or more)

_____Superficial Wrinkles, Fine Lines
_____Acne/Acne Prone / Rosacea
_____Hyper-pigmentation (sun or brown spot)

The Treatment you will receive is a clinical treatment designed to exfoliate or remove the outer (epidermal) layers of the skin. Depending on the treatment, you may experience some temporary burning, itching, stinging, or warm flushing. During the next few hours you may experience mild stinging and tightening of the skin, which may last for several days. Prior to skin sloughing, skin may darken temporarily and then begin the peeling process approximately 2-4 days post-procedure. It is impossible to pre-determine how much peeling will occur. It is common to experience some temporary skin discoloration, dryness and flaking, usually around the nose and lips. Infrequently, a small scab or blister may develop (usually over pre-existing lesion, such as acne or a scaly patch). If this occurs, it should not result in a permanent mark as long as you do not tamper with spot (do NOT pick or peel the affected area) due to risk of scarring or infection.

Your full participation in the skin care treatment, will determine the outcome. It is important that you strictly adhere to the homecare products and regime that your Esthetician/Nurse/Specialist has recommended. It is possible to have a poor reaction, or less than expected improvement of the skin. No guarantee is made or implied as to the precise results, peeling times or discomfort.

Please initial items that apply and that the following points have been discussed with me:

____I am not pregnant or lactating
____I am not allergic to aspirin
____I have disclosed my history of herpes simplex
____I do not have active cold sores
____I agree to follow post-procedure instructions
____I agree to avoid direct sun for 48 hours
____I agree to not wax for 72 hours
____I agree to apply sunscreen protection daily

____I have disclosed all topical prescriptions I am using to my skin care professional
____I have not used Retrin-A or prescription tretinoin within the past 2 weeks
____I have not used Accutane or its equivalent within the past year
____I have not waxed or had laser hair removal in the area to be treated within the past 48 hours
____I agree to notify my Esthetician/Nurse/Specialist of any concerns

I hereby give my consent and authorization voluntarily, and release

Karol A Gutowski, MD LLC and its employees from any claims implied or understood that I have or may have in the future, connected with this treatment, regardless of result(s). I am stating that I fully understand the above precautions, and the treatment was fully explained to me in detail, along with all the risks and benefits. I will notify the office of any adverse effects immediately, and also certify, that if any changes occur in my medical history/health or regime I will notify the office as soon as possible.

Patient (Print Name)	Signature	Date
Witness (Print Name)	Signature	Date