



INFORMED CONSENT FOR DERMAPLANING

I, _____ give my consent for the following procedure:
Dermaplaning to be performed by Revive Medical Spa, LLC.

I understand there are contraindications to this treatment, including but not limited to diabetes, cancer, active acne, bleeding disorder, and the inability for blood to coagulate following injury. Certain medications including blood thinners, higher dosages of Aspirin, and Accutane are contraindicated for this treatment due to the possibility of delayed clotting from a nick or cut.

I certify that I am not taking any of the above medications or experiencing any of the above conditions. Alternative treatments such as waxing to remove vellous hair and microdermabrasion for exfoliation, along with their associated risks, have been explained to me as other options.

I understand this treatment involves the use of a surgical blade to remove dead skin cells and vellous hair. As with the use of any sharp instrument there is the possibility of nicks or cuts. While every precaution is taken, I understand the risks and consent to receive treatment today.

Name _____ Signature _____

Date _____ Witness _____