Clarity Day Spa

AUTHORIZATION AND CONSENT FOR CHEMICAL OR MECHANICAL PEEL AND FACIAL

Procedure: Chemical Peel: This procedure includes washing the face with cleanser then wiping off all excess oils. The peel is then applied using pads or a brush and left on for the predetermined amount of time and then removed. 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. The skin is then patted dry and then a microdermabrasion machine 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 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 treated area may occur. The epidermis may redden (resembling sunburn). Peels do not always involve any visible peeling. There may be a potential risk of developing pigmentation changes in the area treated, which may be temporary. This is the reason sunscreen is so important. For 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 60 days?	[ ] Yes	[ ] No
If yes, state the type of facial surgery and the date:		

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Do you have any allergies?	[ ] Yes	[ ] No
If yes, please list:		

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Do you have a tendency to develop cold sores or fever blisters?	[ ] Yes	[ ] No
Have you had any type of peel treatment in the last 14 days?	[ ] Yes	[ ] No
Are you taking Retin A, Accutane, hormones, birth control pills?	[ ] Yes	[ ] No
If yes, please list:		

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Authorization: I hereby authorize Jane Millican to perform a superficial chemical or mechanical peel procedure on me. I fully understand this procedure has limited applications. I acknowledge I have had the opportunity to ask questions, and I fully understand the treatment of the chemical peel procedure. 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 Jane Millican liability if such results or complications occur. 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 Jane Millican 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 Jane Millican.

MAXIMUM LIABILITY: JANE MILLICAN'S MAXIMUM AGGREGATE LIABILITY TO PATIENT RELATED TO OR IN CONNECTION WITH THE PROCEDURE PERFORMED WILL BE LIMITED TO THE TOTAL AMOUNT PAID TO JANE MILLICAN 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.

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Patient Signature Printed Name Date

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

I hereby authorize Jane Millican to photograph or permit other persons to photograph me before, during and after this procedure. I agree that Jane Millican 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, heath 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 imitation that the patient's name will not be revealed. I understand that I will not be provided with any type compensation or discount if Jane Millican used the negatives, tapes or prints prepared from such photographs.

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Patient Signature Printed Name Date