



**DR SIRUVELLA MD PC
512 Great Oaks Dr
Monroe, GA 30655**

Microdermabrasion Informed and Consent

I, _____, have read the above information and initialed each section to indicate that I fully understand what to expect. If I have any questions or concerns, I will address these with the staff at Signature Medical Aesthetics.

I give permission to Signature Medical Aesthetics, to perform the microdermabrasion procedure we have discussed and will hold the staff harmless from any liability that may result from this treatment.

I understand that Signature Medical Aesthetics will take every precaution to minimize or eliminate negative reactions such as blisters, sores, or other reactions, as much as possible. I have given an accurate account of any over-the-counter or prescription medications that I use regularly and I am not presently using isotretinoin (Accutane).

I have not had any facial surgical procedures or other chemical peels or skin treatments that I have not disclosed to my therapist. I am not ingesting or using topically any other over-the-counter product or prescription medication/agent that has not been disclosed to the staff at Signature Medical Spa.

I am not presently pregnant or lactating and I am over the age of eighteen (18). I have not had any recent radioactive or chemotherapy treatments, sunburn, windburn, or broken skin. I have not recently waxed or used a depilatory (such as Nair) on the area to be treated.

I do not have a history of keloidal scarring, excessive telangiectasia, rosacea, bacterial skin infections, fungal infections, viral infections, open lesions or rashes, active acne, any autoimmune disease, or any other existing condition that may interfere with the positive outcome of this treatment.

I consent to the taking of photographs to monitor treatment effects, as desired or recommended by the staff at Signature Medical Aesthetics.

My expectations are realistic and I understand that the results are not guaranteed.

I agree that I am willing to follow recommendations by the staff at Signature Medical Spa for home care. I will be responsible for following home regimens that can minimize or eliminate possible negative reactions, including recognizing the importance of adhering to a sunscreen and avoiding the sun/tanning booths and extreme weather conditions.

I agree to use a moisturizer specifically recommended by my esthetician and I acknowledge that I have been informed of the possible negative reactions and the expected sequence of the healing process (dryness, irritation, redness, and peeling of the skin).



In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post-treatment care, I will consult my therapist immediately.

I understand the potential risks and complications and have chosen to proceed with the treatment after careful consideration of the possibility of both known and unknown risks, complications, and limitations.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and fully understand the above paragraphs and that I have had sufficient opportunity for discussion to have any questions answered.

Client Name (printed)

Client Name (signature) _____

Date _____

Esthetician _____

Date _____