Consent for Microdermabrasion (MDA) Treatment

I, __________________________, understand that Microdermabrasion (MDA) treatment is intended to reduce the appearance of skin imperfections such as stretch marks, age spots, fine lines, acne scars and scars resulting from surgery or injury, and that clinical results may vary in different skin types. There are several alternatives to treatment including but not limited to topical treatments, laser treatments, or no treatment at all.

I understand that MDA is a superficial mechanical abrasion to the skin which is accomplished by using a machine (microdermabrader) that delivers a blend of Aluminum Oxide crystals and a vacuum, and that Aluminum Oxide is an inert crystal known for its abrasive qualities. I understand that the primary purpose of this procedure is to prepare the skin to accept, and increase the absorption properties of active ingredient rejuvenation products, and/or chemicals.

I understand that MDA procedures are a superficial abrasion to the skin and that the result of a one-time treatment is similar to a deep cleansing or polishing of the skin. I understand that in order to see significant results, treatments need to be done in a series, and in combination with active ingredient skin care products.

I understand that compliance to my after care instructions will greatly affect my final result and that complete compliance to my ongoing skin care program will enhance the outcome of my MDA treatments. I understand that I must use a Protective Moisturizer with SPF 30 over the treated areas on a daily basis during my treatment series.

I understand that there can be no guarantee as to how effective the outcome of my treatment(s) will be. There also can be no guarantee that dark discoloration (melasma) or stretch marks, will be reduced or fade. I understand, that these conditions will respond much better when part of an overall skincare program.

I understand that after my MDA procedure all treated areas may appear sunburned and feel warm as if sunburned or wind burned and that my skin may feel dry and sensitive for a few days following treatment. I understand that acne conditions may temporarily appear worse for a few days following treatment. I understand that the risk of eye injury is possible but unlikely, providing complete eye protection is properly used throughout the treatment sessions.
I certify that I do not have any of the following conditions which are CONTRAINDICATIONS to MDA treatment: active, uncontrolled or brittle diabetes, Viral lesions, Herpes Simplex, Shingles, Eczema of Seborrheic dermatitis, active Rosacea, Oral blood thinners, Skin cancer and auto immune disorders such as AIDS or HIV, Vitiligo, Telangectasis, Visible, broken blood vessels, Sunburned skin, keratosis, undiagnosed lesions, weeping acne (stages 3 to 4), fragile capillaries, eczema, dermatitis, psoriasis or lupus.

I understand that the treatment by the MDA system involves payment, and the fee structure has been fully explained to me. With this in mind, I am choosing to try MDA to reduce the appearance of skin imperfections such as stretch marks, age spots, fine lines, acne scars and scars resulting from surgery or injury.

☐ I give permission for any pictures or videotape taken of me may be used for either teaching or publication, if considered appropriate.

☐ I give permission for my pictures to appear in MedThin’s photo album for other potential patients to view.

I have been given the opportunity to ask questions about my condition and the treatment, alternative forms of treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I have sufficient information to give this informed consent.

I certify that I have completely read the above form and the form has been fully explained to me, and I understand its contents. I understand that every effort will be made to provide a positive outcome, but that there are no guarantees. I understand the procedure and risks, and accept the risks, and request that this procedure be performed on me by qualified staff.

Patient Name (print)________________________

Patient Signature_________________________ Date____________

Witness Name (print) ________________________

Witness Signature_________________________ Date ____________