CONSENT FOR ILLUMINIZE OR VITALIZE PEEL

Please, read the following and initial:

_____ I understand that Illuminize/Vitalize Peel is indicated for mild to moderate conditions of photodamaged skin, fine lines and wrinkles, pigmentary irregularities, including melasma, superficial scarring and acne. I understand to achieve best results, a program of six consecutive in-office applications should be undertaken at three to four weeks apart.

_____ I understand that this is a cosmetic treatment and there are no guarantees as to the results of this treatment, known as the Illuminize/Vitalize Peel.

_____ I understand there are many variables, such as age, condition of skin, sun damage, etc., that affect the outcome of this treatment; therefore, there has been no guarantee made to me concerning the outcome or results from this treatment. I also understand that I may or may not peel from this treatment.

_____ I understand that multiple treatments are often needed in order to receive desired results.

_____ Prior to receiving this treatment, I have fully disclosed my past and present medical history, including any condition and/or medication that would cause me to not be a candidate for this procedure. These conditions may include, but are not limited to: recent facial surgery, certain allergies, tendency for cold sore/fever blisters, use of Retin-A, Accutane, Differin, Tazorac, or related product, etc.

_____ I certify that I have ceased use of Hydroquinone, Salicylic acid, Azelaic acid, and retinoids (Retin-A, Renova) products at least one week prior to receiving this treatment.

_____ I understand this procedure may include some degree of discomfort, stinging, pin-pricking sensation, burning and/or tightness.

_____ I assume all risks associated with this procedure. I also understand that this treatment may involve complications or injury from both known and unknown causes.

_____ I understand that the possible side effects of this treatment may include, but are not limited to: redness of the skin, flaking, irritation, scabbing, mild to moderate discomfort, swelling, scarring, and/or cold sores. I understand that, in rare instances, this treatment may result in hyper and/or hypo-pigmentation. If I experience any side effects and/or complications, I agree to contact Dr. Alan M. Gardner or his certified technician.

_____ I understand that I MUST use a broad spectrum sunblock, such as SkinCeuticals Ultimate UV Defense SPF 30, at all times throughout the course of the treatment.

_____ I have received and understand post treatment instructions and skin care recommendations. I agree to comply with all instructions.

_____ I agree to refrain from tanning while I am undergoing treatment and for two weeks following treatment. Tanning includes exposure to natural sunlight and tanning beds.

_____ I consent to the taking of medical photographs by Alan M. Gardner, M.D. or his staff. I give permission for Dr. Alan M. Gardner or his certified technician to use my photographs for the purpose of medical records, education, publication, web site or as he deems proper.

_____ I certify that I am at least 18 years of age (minors require the signature consent of parent/legal guardian). I agree that this constitutes full disclosure and that it supersedes any previous verbal or written consent. I certify that I have read and fully understand the above information; and, that I have had sufficient opportunity for discussion and to ask questions. I certify that all of my questions have been answered to my satisfaction.

Please, sign below to indicate that you have read and understand the statements above:

By signing this consent form, I confirm I have read this consent form and the consent form has been explained to me in terms which I understand. I have had the opportunity to ask questions and receive answers regarding this procedure, I understand the risks associated with this procedure and have told of any alternative treatments available and would like to proceed with this treatment today. I understand this is not a medically necessary procedure. The Illuminize/Vitalize Peel is a cosmetic procedure and is not covered by any health insurance plan. I accept responsibility for all costs associated with this procedure and agree not to submit this procedure to any health insurance plan.

PATIENT (PRINT) NAME: ____ DATE: ____________

PATIENT SIGNATURE: ____ DATE: ____________

WITNESS SIGNATURE: ____ DATE: ____________