Dermaplaning consent form

DO NOT SIGN UNLESS YOU FULLY UNDERSTAND AND AGREE

Date: _____

Name: _____

DOB: _____

I understand that Dermaplaning involves the use of a sterilized surgical-type blade to remove fine vellus hair from the face and provide light exfoliation. The blade is held at a 45-degree angle and stroked along the face.

I acknowledge that as a blade is used for this treatment, there is the possibility of nicking or cutting the skin. Our technicians have been thoroughly trained in the procedure and have previous experience performing the Dermaplaning treatment.

I have been informed that the Dermaplaning treatment does not cause the hair to grow back thicker or darker. The structure of the vellous hair (thin, translucent blonde hair) is not damaged during blading and grows back the same.

I understand that all skin types can benefit from Dermaplaning. However, this treatment is not recommended for those suffering from severe acne and/or over production of the sebaceous glands.

Possible side effects of the Dermaplaning treatment can include redness, irritation, and dryness. Peeling of the skin is uncommon however can occur following the Dermaplaning treatment. Infection and scarring are rare, unlikely complications.

The nature of the Dermaplaning treatment has been explained to me. I understand that just as there may be benefits from the procedure, all procedures involve risk to some degree.

Do not sign this form unless you have read it and believe that you understand it. Ask any questions you might have before signing this form.

I agree to be a polite, realistic and compliant patient.

I agree to follow the ACM social media policy and pay all costs incurred by ACM if I breach this policy.

I HAVE READ THIS FORM AND UNDERSTOOD THIS FORM AND I REQUEST THAT THIS PROCEDURE BE PERFORMED ON ME.

Patient's Signature: _____

Witness's Signature: _____

Date: _____