



## VI Peel™ Consent Form

The VI Peel™ contains a synergistic blend of powerful ingredients suitable for all skin types. VI Peels™ will improve the tone, texture and clarity of the skin; reduce age spots, improve hyperpigmentation (including melasma), soften lines and wrinkles; clear acneic skin conditions; reduce or eliminate acne scars; and stimulate the production of collagen, for firmer, more youthful skin.

### Contraindications:

- Patients who are pregnant or who are breast feeding
- Patients who have an aspirin allergy or phenol allergy
- Patients who have used Accutane within the past 3 months
- Patients who have active cold sores, warts, open wounds or history of herpes simplex
- Patients who are undergoing chemotherapy and or radiation therapy
- Patients with a history of an autoimmune disease or any condition that may weaken their immune system

Please read and initial the following:

\_\_\_\_ Prior to receiving treatment I have communicated with the Practitioner about any conditions or medications that may contraindicate this procedure.

\_\_\_\_ I understand that there may be some degree of discomfort such as burning, stinging, redness, heat or tightness during and a week after the procedure.

\_\_\_\_ I understand that there is no guarantee of the final results of the peel. Occasionally hyperpigmentation may develop which may persist for week or months after the peel.

\_\_\_\_ I understand although complications are very rare, sometimes they may occur. In the event of any complications, I will immediately contact the Physician/Clinician who performed the treatment.

\_\_\_\_ I understand that maintenance VI Peel™ treatments are necessary to maintain results as well as the recommended VI DERM™ skin care regimen.

\_\_\_\_ I understand the extended direct sun exposure including tanning beds are strictly prohibited before and after receiving the VI Peel™.

\_\_\_\_ I understand that I must protect my skin with VI DERM™ SPF 50+ and avoid sun exposure during the exfoliation process.

\_\_\_\_ I understand that this is an elective cosmetic procedure and is non-refundable. I understand payment is my sole responsibility.

\_\_\_\_ I understand that no other chemical peels or medical device treatments may be performed on my skin until my physician/clinician releases me to do so.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
date