

DERMASOUND CONSENT FORM

My signature below acknowledges that I have read the following and agree to receive treatments or a series of treatments listed below.

I hereby consent to, and authorize _____, to perform DermaSound Elite Ultrasonic and microcurrent treatments on me.

Areas to be treated _____

- I understand that with any treatment certain risks are involved and that any undesirable effects from known or unknown causes could occur. I freely assume these risks.
- Possible side effects include, but are not limited to: mild to moderate redness, mild breakouts, tenderness, dry skin, flaking, lightening or darkening of the skin. Most side effects are temporary and generally subside within 72 hours.
- I have been advised to avoid all injectables including but not limited to collagen, Restalyn, Botox, Voluma, Juvaderm injections for a minimum of 14 days before any Derasound Ultrasound treatment and a minimum of 7 days after a Derasound treatment.
- I agree to adhere to all safety precautions and home skin care programs as recommended by my esthetician.
- I am over the age of 18 and I have parental consent co-signed below.
- I do not have a pacemaker or any other electronic device in my body.
- I will call to inform my skincare professional immediately of any concerns if they may occur.

Please Initial

_____ I am not pregnant.

_____ I agree to avoid direct sun exposure for 48 hours.

_____ I agree to apply sun protection daily.

_____ I agree to remove all jewelry during the treatment.

_____ I have not taken Accutane within 6 months.

_____ I do not have a pacemaker or any other electrical device in my body.

_____ I agree to follow a Glymed homecare protocol.

_____ I agree to notify my skin care professional immediately of any concerns if they should occur.

_____ I agree to avoid all injectables and fillers for a minimum of 14- 21 days prior to any Derasound treatment.

Client Signature: _____ Date: _____

Parental Signature: _____ Date: _____