CONSENT FORM TO DERMAPLANE
AND POST TREATMENT

(Please read carefully and completely the following information and acknowledge that you understandand accept all provisions by signing below).

I_____, acknowledge and agree to hold **Brows By Nikki, LLC** or any of their associates harmless against any and all liability and claims for injuries or any occurrences of events directly caused by active negligence of **Brows By Nikki, LLC** or any associates.

I realize that the goal of the dermaplane procedure is to manually remove surface cellular debris, vellus hair which provides skin exfoliation and skin rejuvenation.

I understand that this procedure uses a disposable medical blade, which has a keen edge. Therefore, I will follow the explicit instructions of my skin care professional or medical professional.

I have been advised of certain services should be avoided for one week after my dermaplane service,which may include: light chemical peels, LED light therapy, microcurrent, high frequency, microneedling, galvanic, laser hair removal, light enzymes, nanoneedling, ultrasound therapy.

The nature and purpose of the treatments have been explained to me and any questions that I have regarding this procedure and/or post treatment options have been explained to my satisfaction.

I understand that my skin care professional can discover other or different conditions that may require additional or different procedures than those planned. If my skin care professional discovers such other,or different conditions, I will be referred to the appropriate medical care provider as needed for further assessment.

I acknowledge that the practice of esthetics is not an exact science and that no specific guarantees can or have been made concerning the expected result.

If I am prone to reactions to nickel (a substance found in blade metal) I have been advised that some erythema (redness) may present and that this should be short live I understand that as with any treatment certain risks are involved and that any complications or side effects from known or unknown causes could occur. I freely assume these risks.

If I am prone to herpes outbreaks, I have been advised to see my physician regarding a prescription as needed.

I acknowledge my obligation to follow the written and/or spoken instructions related to my pre and post procedure home care regime.

I agree to all safety precautions and homecare programs as recommended by my skin care professional.

I am over 18 years of age and/or I have a parental consent co-signed below.

I will contact this office/skin care practice to inform my skin care professional of any complications or concerns as soon as they occur.

I have read the contents and I fully understand them. I have been given sufficient opportunity for discussion and all my questions have been answered to my satisfaction. I hereby consent to the DERMAPLANING procedure and recommended post treatment protocol.

Client signature_____ Date_____

Print name_____

Address: _____City: _____ State: _____ Zip: _____

Date of Birth (MM/DD/YYYY): _____ Phone Number: _____

Email: _____

Brows By Nikki Skin Care Professional signature_____

Print Name_____

Date_____