austinclinic
No one understands your skin better

Dr Susan Austin
Provider No: 049332LX

Hydrafacial MD Consent

I understand that Hydrafacial MD is used to treat acne and associated scarring, large pores, pigmentation, fine lines and wrinkles, and to improve tone, texture and general skin health. I understand that clinical results can vary according to skin type, that there is no guarantee of a particular result and that I am paying for treatment and not the result.

I understand that to gain maximum effect of Hydrafacial MD a treatment once per month is recommended.

I understand that the potential side effects can include temporary redness and scaling of the area treated.

I will endeavour to stay out of the sun as much as possible for two days following treatment.

All my questions and concerns have been fully answered and with this in mind I am choosing to try Hydrafacial MD for treatment of my skin. I understand that payment is required for this treatment at the time of consultation and I agree to be bound by the fee structure, which has been fully explained to me.

I am not allergic to Salicylic acid.

I have not taken Roaccutane in the last twelve months.

I have read this consent form in full and give consent to this treatment.

PATIENTS NAME .....

SIGNATURE .....

DATE .....

WITNESS .....