SEGO LILY
SPA

Dermaplaning Consent Form

I understand that Dermaplaning involves the use of a surgical blade to remove fine vellus hair and dead layers of skin from the face.

The nature and purpose of this treatment has been explained to me and any questions I have regarding the treatment have been answered to my satisfaction.

I understand that the treatment may involve the risk of complication or injury and I freely assume those risks. Possible side effects of the treatment area can include mild redness of the skin, irritation and dryness. Additionally, very rarely nicks to the skin can occur due to the sharp surgical blade being used during treatment.

The hair is expected to grow back blunt-ended. New hair will not appear darker or denser. However, I do understand that any hormonal imbalance that may be present within my anatomical system can alter normal hair growth patterns.

If a chemical peel is part of this treatment, I understand that the sensation and penetration of the peel will be enhanced. Which may cause skin irritation, mild discomfort, and tenderness, lightening or darkening of the skin, infection, scarring, peeling and activation of cold sores.

I understand the possible side effects associated with this procedure and I have voluntarily decided to continue with the treatment. I understand that I should notify my practitioner of any side effects.

I understand that to achieve maximum results with my skin care treatments- I may need several ongoing treatments and use a daily product over a period of time, including sunscreen.

I understand that I cannot have this procedure if I have any sunburn or have been recently exposed to the sun preceding this procedure.

I have not had any recent radioactive or chemotherapy treatments, sunburn, windburn, or broken skin. I have not recently waxed or used a depilatory on the area to be treated. I don't have a history of keloid scarring, diabetes, any autoimmune disease, active herpes blisters, or any other existing condition that may interfere with the positive outcome of this treatment.

I acknowledge that I have been given post-treatment instructions and that I will follow the home care program specifically designed for me without changing or adding any products.

I certify that I have read this entire informed consent and that I understand and agree to the information provided in this form.

_____	_____	_____
Guest Signature	Print Name	Date