the saltFACIAL®
THE SCIENCE YOUR SKIN NEEDS.

(SAMPLE) Treatment Consent Form

The SaltFacial®

I,_____ (print name) consent to undergo *The SaltFacial®* treatment as described to me by my skincare professional. It has been explained to me that *The SaltFacial®* treatment is a safe, 3-step process comprised of Step (1): Sea Salt Resurfacing, Step (2): Aesthetic Ultrasound, and Step (3): LED Phototherapy.

It has been explained to me and I understand that although results may be seen with as little as one treatment, a series of 4 to 8 treatments may be recommended based on my skin care goals.

_____ (Initial here)

The SaltFacial® is considered a non-invasive treatment, meaning it does not break the skin barrier. Because of this, complications are rare, however it has been explained that I may experience some post-treatment redness, swelling, sloughing, and flaking of the treated area. I understand this is a normal response that can last for as little as a few minutes or up to several days following treatment. My skincare professional has explained the treatment expectations and I am in full understanding of this.

_____ (Initial here)

For more aggressive treatments, post-treatment scabbing may occur. This more aggressive type of treatment may be performed if my skincare professional has recommended it based off my desired treatment goals. Aftercare instructions for this type of treatment have been explained to me and are fully understood.

_____ (Initial here)

I acknowledge that I have provided my full medical history, including all medications and supplements I'm currently on.

_____ (Initial here)

I have informed my skincare professional of any use of Accutane within the past 12 months.

_____ (Initial here)

I have been instructed to discontinue use of any product containing Retin-A, retinoids, retinols, Glycolic Acid, or AHA, for 3 to 5 days PRE-treatment and 3 to 5 days POST-treatment. I acknowledge that my skincare professional has answered all of my questions, and the treatment has been explained to my satisfaction.

_____ (Initial here)

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It has been explained that photos will be taken before and after treatment to track my progress. I understand these photos will remain the property of this office and will not be used for any other purpose unless I agree to release them for use.

_____ (Initial here)

Photo Release

I agree to release my photos to my provider to use for promotional purposes, and for possible submission to the manufacturer to use for promotional purposes. It has been explained that even if the photos are chosen for use, my identity will be kept private and secure.

_____ (Initial here)

Patient Name: _____

Patient Signature: _____ **Date:** _____