RATIONALE ENZYME REACTIVATION TREATMENT CONSENT

ONLY SIGN IF YOU FULLY AGREE AND UNDERSTAND

ABSOLUTE
COSMETIC MEDICINE

- ☐ I confirm that I do not currently have any conditions which may prohibit this treatment, such as cold sores, use of hormones, recent facial surgery or laser resurfacing, and I have not used any acne-related drugs within the last 12 months.
- ☐ I am not pregnant or breastfeeding.
- ☐ I understand that there are no guaranteed results from this treatment.
- ☐ Results may vary due to several different factors, such as age, sun damage, on-going sun exposure, smoking, excessive alcohol intake, climate, diet and water intake, skin thickness and sensitivity.
- ☐ I understand that my skin may or may not peel and that each case is individual.
- ☐ Regardless of precautions taken, I acknowledge the possibility of an adverse reaction to the Enzyme Reactivation Treatment and I accept sole responsibility for any medical care that may become necessary. Should an adverse reaction occur I will immediately contact the Doctor, nurse or skin technician performing this treatment.
- ☐ I will not scratch, pick, pull at or abrade the treated skin.
- ☐ I understand that direct sun exposure and the use of tanning booths is prohibited during this treatment time (should on-going treatments be necessary) and that mandatory use of a minimum SPF 20 sun protection cream is required daily.
- ☐ I understand that to achieve maximum results the recommended home care routine must be followed. I understand that if I alter the routine or use products not recommended by the skin care professional that the results could be altered or inhibited. I also understand that it may take several treatments to obtain the desired result.
- ☐ I understand that the following side effects and complications, although extremely unlikely, can occur: Discomfort, redness and swelling, hypopigmentation, itching and irritation, skin peeling or flaking up to 14 days after procedure, infection, scarring, hyperpigmentation and acne breakouts.
- ☐ I understand the goals of the treatment, as well as the limitations and possible complications.
- ☐ The skincare professional has provided sufficient information and has answered all my questions concerning this procedure. I clearly understand the above information.
- ☐ I confirm I am not currently using any prescribed vitamin A or keratolytic products (i.e. Retrieve, Stieva- A, Retin A, Isotrex, Differin).
- ☐ I confirm I am currently not taking an Isotretinoin medication (i.e. Roaccutane, Isotrex, Isohexal, Oratane).
- ☐ Have you had an AHNBHA peel or chemical peel, or Enzyme Reactivation Treatment, IPL or laser treatment in the past 2-3 weeks?
  If so, when and what treatment was it?

  _____

  _____

- ☐ Do you wear a sunscreen everyday?
  If not, are you prepared to wear a sunscreen?

  _____

  _____

- ☐ I understand I am not to use skincare products that contain acids for the next 24 hours.

Date: _____

Patient signature: _____

Skin technician signature: _____

Print name: _____

I cannot dispute what I have read, agreed to and signed above . If I do then I agree to pay all costs incurred by ACM if I breach this agreement.
I agree to follow the ACM social media policy and pay all costs incurred by ACM if I breach this policy.
I understand that photographs are for clinical use only. I am responsible for taking my own photographs for my records.
(please initial) _____

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