Semone Rochlin D.O.
COSMETIC & RECONSTRUCTIVE SURGEON
BOARD CERTIFIED GENERAL SURGEON

CLINICAL SKINCARE CONSENT & RELEASE FORM

Dermapen, Facials, Peels, Microdermabrasion, Dermaplane, Waxing, & Micropeel Consent
Any treatment we provide may consist of surface cleansing, superficial chemical peels, steam, exfoliation, application of antibacterial serums, corrective serums, and extractions. Treatments are designed to balance, hydrate, clear acne impactions, and prepare the skin for a home care regimen. Although rare, skin care treatments can have certain side effects such as erythema, bleeding, temporary scarring, dryness, discomfort, redness, rash, swelling, tenderness, etc.

I hereby consent to and authorize Dr. Rochlin and/or staff to perform any of the treatments listed above. I have voluntarily elected to undergo this treatment. Although it is impossible to list every potential risk and complication, I have been informed of possible benefits, risks, and complications. I also recognize there are no guaranteed results and that independent results are dependent on age, skin condition, and lifestyle and that there is the possibility I may require further treatments of the treated areas to obtain the expected results at an additional cost._____ (initial)

I understand the post treatment home care instructions. I understand how important it is to follow all instructions given to me for post treatment care. In the event that I may have additional questions or concerns regarding my treatment or suggested home product/post treatment care, I will consult the office immediately._____(initial)

I have also, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically._____(initial)

I have read and fully understand this agreement and all information detailed above. I understand the treatment and accept the risks. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. I do not hold Dr. Rochlin and/or staff responsible for any of my conditions that were present, but not disclosed at the time of the skin care procedure, which may be affected by the treatment performed. I consent to treatment today and all subsequent treatments._____(initial)

PHOTO RELEASE
I understand that photographs may be taken before, during and after treatment. I give permission for photographs to be used by Dr. Semone Rochlin, D.O. and/or staff for educational and/or promotional purposes. Complete patient confidentiality will be maintained at all times._____(initial)

CANCELLATION/RESCHEDULING GUIDELINES
We realize emergencies happen and will be considered, however, it is our office policy to apply a $45 charge to your account for a cancelled or rescheduled appointment with less than 24 hour notice. A $90 charge will be applied to your account with less than a 1 hour notice._____(initial)

CLIENT NAME (printed)_____

CLIENT NAME (signature)_____ Date_____