Informed consent for the use of Gluconolactone 20% and 50% solution

Patient Full Names and Surname_____

Patient Identity Number_____

Address _____
City/Town _____ Postal Code _____

Phone no_____Attending doctor/Clinic_____

I, the Patient/client, by signing this form, confirm the following:

1. I am over the age of 12 and of sound mind and sufficient maturity to understand the nature, risks, benefits and consequences of the treatment. I have not been forced, pressurized or unduly influenced to sign this consent. 2. The doctor has informed me of my health status and diagnosis (i.e. how my health appears to be, or what s/he has confirmed by examining me and / or conducting tests and /or by observing the effects of previous treatment) which I understand as _____

3. The doctor has explained to me the available treatment options as well as the costs of such treatment for my condition. I fully understand that apart from the glycolic acid peel there are alternative treatments available for the reduction of wrinkles, the treatment of various skin conditions such as oily and acne type skin, brown spots, scars, and thick skin. These alternative treatments include but are not limited to other prescription or non-prescription topical regimens, other chemical peels, laser treatments, Botox injections, dermal fillers, and surgery.

4. I hereby consent to treatment by means of a gluconolactone peel 20% / 50% solution (delete which is NOT applicable) solution. I understand the gluconolactone peel is a topical medical treatment designed to help reduce fine wrinkling or alterations in pigmentation as well as to enhance the general appearance and complexion of my skin. Gluconolactone is a medical grade product that is produced from chemical compounds and highly effective as an exfoliate. I understand that the use of photosensitizing drugs such a Retin-A®, Ilotycin A®, Renova®, Retacnyl®, Differen®, Zorak®, Accutane®, Roaccutane® or its generics, other retinoic acid products, Alpha-Hydroxy Acid products or bleaching agents and certain photosensitizing antibiotics may be contraindicated and medication and creams that I am using must be disclosed to and discussed with the doctor prior to consent. I understand that I must not start any new medications or creams without informing the doctor so that s/he can advise me about any potential complications with my skin treatments.

5. I hereby authorize and direct Dr/Clinic _____ or any licensed doctor of this practice to perform the gluconolactone peel on me. The exact solution for my treatment, as well as the recommended sequence of treatments has been explained to me.

6. I have been informed of the nature, possible risks and complications of the gluconolactone peel including but not limited to stinging, burning, and itching of the superficial layers of the skin. Should flaking occur this should not continue for more than 7 days. In rare cases it may last longer. Commonly I may not experience flaking at all. I understand and confirm that I must contact my doctor or the practice if I experience or develop any health problems, other side-effects or symptoms after the treatment such as:

● a significant skin rash or condition ● an allergy to one or more peel components ● crusts or weeping of the skin ● painful sores at the site of the peel

7. While serious complications are not common, possible side effects may occur. They include but are not limited to: transient facial skin tightness, itching, redness, flushing, stinging or burning, and peeling. Possible complications include allergic reactions to the gluconolactone acid solution or other Pre-Peel or Post-Peel ingredients, reactivation of prior known or unknown Herpes infections, bacterial or fungal infections, persistent erythema, persistent areas of

hyperpigmentation or hypopigmentation, irregularities in skin complexion, or scarring. Known significant risks have been disclosed, yet the theoretical risk of unknown complications does exist.

8. These side effects and/or complications may result in time away from work or other activities. I understand that there is a possibility of rare side effects such as scarring and permanent discoloration, as well as short term effects such a reddening, mild burning, skin flaking, temporary discoloration of the skin. These effects have all been fully explained to me. In particular, I should not have a glycolic acid peel if I am:

● Pregnant or breastfeeding (discuss the benefits and risks with the doctor first) ● Under the age of 12 years ● Allergic to any of the ingredients found in the priming regimen (tretinoin, glycolic acid, kojic acid, lipo-amino acid, hydroquinone, Vitamin C, hydrocortisone, and others) or allergic or sensitive to the ingredients found in the peeling solution (Gluconolactone, Glycolic acid, Phytic acid, Citric Acid, Mandelic acid) ● Affected by a skin condition including but not limited to: Psoriasis, systemic lupus erythematosis, active Herpes infection, open sores or bites, non-healing sores, eczema, moderate to severe acne, erysipelas, sun burns, chemical or electrical burns, frostbite, facial surgery in the last 3 months including facelifts or eyelid surgery, or active skin infections ● Taking or have taken Accutane® in the last year ● Unwilling to comply with the Pre-Peel or Post-Peel instructions.

9. I agree to follow-up periodically as directed by my doctor to monitor progress as well as to screen for possible side effects. My doctor may choose to discontinue the medical regimen for any reason including development of side effects or complications, failure to comply with instructions, or failure to follow-up as directed.

10. I also understand that I may refuse and / or terminate treatment at any time and that the implications of my decision and potential consequences have been explained to me. I confirm that I will not hold the doctor liable for any of those consequences, should they happen. I also understand that if I refuse the treatment, I / the person responsible for the account must still pay for the consultations and treatments I have received.

11. I confirm that no warranties, assurances, or guarantees of successful treatment or the levels of improvement have been made to me. Response to treatment, if any, will be gradual and may take weeks to appreciate. Unless maintained periodically, the effects will diminish over time. I understand that the use of gluconolactone cannot guarantee results.

12. I authorize the taking of clinical photographs before, during, and after the treatment and that these photographs shall remain the property of the doctor and the practice, and agree to their use for scientific and educational purposes both in publications and presentations. I understand my identity will be protected at all times.

13. I agree to undergo this treatment after having considered all the information contained in this document, the information provided to me through my conversation with my doctor and through information materials provided to me by the office to educate me about the treatment.

14. I confirm that all the health information disclosed to my doctor is correct and that I have had the opportunity to ask any questions of my doctor with respect to the proposed therapy and the procedures to be utilized, and that all of my questions have been answered to my full satisfaction.

15. The doctor has explained to me the costs of the therapy and /or treatment as well as the fact that my medical scheme may not reimburse the costs of the treatment. I understand that payment for the treatment is subject to the terms and conditions of the practice and that I am aware of these terms and conditions.

16. I confirm that I understand what is written in this document and what the doctor has explained to me before I signed it. I also confirm that I can request any further information and / or ask the doctor anything relating to the treatment, even after I have signed this form.

_____ _____

Patient's Signature **Date Signed**