ART QUINTANILLA, MD
BOARD CERTIFIED PHYSICIAN

DESERT MEDICAL REJUVENATION

35900 BOB HOPE DRIVE SUITE 130
RANCHO MIRAGE, CA 92270
PHONE: (760) 832-7279

PCA FACIAL CONSENT FORM

Prior to receiving treatment, I have been candid in revealing any condition that may have bearing on this procedure, such as: pregnancy (if so, consult your physician prior to treatment), recent facial surgery, allergies, tendency to cold sores/fever blisters, or use of topical and/or oral prescription medications such as: tretinoin, Retin-A®, isotretinoin, Accutane®, Differin®, Tazorac®, Avage®, EpiDuo® or Ziana®._____ **(Please initial)**

I understand there may be some degree of discomfort such as stinging, pin-prickling sensation, heat or tightness. _____ **(Please initial)**

I understand there are not guarantees as to the results of this treatment, due to many variables, such as: age, condition, of skin, sun damage, smoking, climate, etc. _____ **(Please initial)**

I understand this treatment is a cosmetic treatment and that no medical claims are expressed or implied._____ **(Please initial)**

I understand that to achieve maximum results, I may need several treatments. _____**(Please initial)**

I understand that although complications are very rare sometimes they may occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the physician/clinician who performed the treatment. _____ **(Please initial)**

I agree to refrain from tanning beds or outdoors while I am undergoing treatment, and during the 14 days prior to and following the end of treatment. This practice should be discontinued due to the increased risk of skin cancer and signs of
aging. _____ **(Please initial)**

I understand that extended direct sun exposure is prohibited while I am undergoing treatment, and the daily use of sunscreen protection with a minimum of SPF 30 is mandatory. _____**(Please initial)**

I understand that I should follow my clinician's recommendations for post-procedure skin care to minimize side effects and maximize results. _____ **(Please initial)**

I hereby further to agree to all the above and agree to have this treatment performed on me. I further agree to follow all post-peel care instructions as I am
directed. _____ **(Please initial)**

I consent to and authorize the healthcare facility located at 35900 Bob Hope Drive Suite 130, Rancho Mirage, CA 92270, to take all necessary photographs before and after my procedure._____ **(Please initial)**

DATE: _____	INITIALS _____
DATE: _____	INITIALS _____
DATE: _____	INITIALS _____
DATE: _____	INITIALS _____
DATE: _____	INITIALS _____
DATE: _____	INITIALS _____
DATE: _____	INITIALS _____

Patient Signature: _____ Date: _____

To be filled out by office personnel:

Esthetician: _____ Date: _____

Witness: _____ Date: _____