DESERT MEDICAL REJUVENATION
REGAIN YOUR YOUTHFUL APPEARANCE

ART QUINTANILLA MD
BOARD CERTIFIED PHYSICIAN

INFORMED CONSENT FOR PCA FACIAL

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®. _____**(Initial)**

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

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

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

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

Patient Name_____

Patient Signature_____

Date_____

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ART QUINTANILLA MD
BOARD CERTIFIED PHYSICIAN

Witness
Name_____

Witness Signature_____
Date_____

Esthetician
Name_____

Esthetician Signature_____
Date_____

CONTINUED TREATMENT CONSENT

Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____

DESERT MEDICAL REJUVENATION 35900 BOB HOPE DRIVE SUITE 130 RANCHO MIRAGE, CA 92270 (760)832-7279 F: (760) 832-7505