Grandview Aesthetic Medicine
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Consent Form for Dermaplaning

Patient Name:_____ Date: _____

Grandview Aesthetic Medicine believes its clients have the right to be informed of each treatment to make an informed decision to proceed with a treatment. Dermaplaning, as with many cosmetic procedures does have risks, although they are very rare, they are a possibility.

_____I understand that Dermaplaning involves the use of a surgical blade to exfoliate the skin and remove fine vellus hair from the face.

_____I have been informed about the treatment and everything has been explained to my satisfaction.

_____I understand there is a risk of injury and I agree to assume those risks. These risks include irritation, dryness and redness of the skin being treated. I understand that the treatment may involve the risk of complication or injury and I freely assume those risks. Possible side effects of the treatment area can include mild redness of the skin, irritation, and dryness. Due to the use of a surgical blade in this treatment, there is a possibility of small cuts to the skin being treated.

If Microneedling or Injections are part of this treatment: I understand that the sensation and penetration of the secondary service will be enhanced. This may cause skin irritation, mild discomfort, tenderness, lightening or darkening of the skin, infection, scarring, peeling, and activation of cold sores.

I certify that I have read this entire consent and that I understand and agree to the information provided in this form. I certify that I am 18 years of age, or I have a parental consent co-signed below.

I will call to inform my provider of any complications or concerns as soon as they occur.

I certify that I have read the above consent and I fully understand it and I herby consent to the Dermaplaning treatment.

Patient Signature:_____ Date: _____