CONSENT FORM

SKIN TECH® PHARMA GROUP

PEELINGS

I, _____ with ID Nº: _____
residing at _____

HEREBY REQUEST AND AUTHORISE Dr. _____ (Hereinafter, the "SQMP") assisted by the suitably qualified medical professional (SQMP) and medical staff he/she deems necessary to carry out on me (or represented party), a chemical peeling of the following type: (x right option)

☐ Very superficial (intraepidermic) ☐ Superficial (basal layer) ☐ Intermediate (Grenz zone)
☐ Medium (papillary dermis) ☐ Deep (reticulate dermis)

1. I HEREBY CONFIRM I have had explained in detail, using words which are comprehensible to me, the effect and nature of the peeling to be carried out and other alternative treatment solutions (if existing), likewise the discomfort which may be felt even for normal post peeling.
   All the questions asked regarding the entire procedure have been answered to my satisfaction.
2. There is a relation between depth of the peelings and level of risk; it must be borne in mind that a deep peeling involves a much higher risk of complication than a superficial one.
   Complications described (not a limited list)
   - Insufficient results, transitory or definite change of skin colour depending on peeling, oedema and/or prolonged erythema, telangiectasias, scarring, infections, ectro or entropion, milia, acne type reaction, pain, demarcation line, dilated pores, purpura, petechiae, benign pigmentation of nevi.
   - In the case of complete face deep peelings, and if phenol is used, possible general toxicity should be considered depending on dose used and application speed. In this case prior blood analysis is required likewise eventual cardiological examination.
3. I GIVE MY CONSENT to the eventual use of anaesthetic by or as instructed by the surgeon or anaesthetists selected by the same. I accept the eventual risks of said anaesthesia.
   In your case, the peeling requires: (x right option)

   ☐ No anaesthesia whatsoever ☐ Topical anaesthesia, ☐ Local anaesthesia,
   ☐ Anaesthesia via nerve blocks, ☐ Deep sedation or neuroleptoanalgesia, ☐ General anaesthesia

4. I ACKNOWLEDGE that during the course of the peeling, unexpected conditions may arise making it necessary to change that already planned, and I DO HEREBY EXPRESSLY AUTHORISE treatment thereof, including any kind of procedure which might be necessary. Furthermore, I HEREBY AUTHORISE the doctor request the assistance of any other specialists as per his/her professional criteria.
5. I UNDERSTAND the aim of intervention request is to IMPROVE MY APPEARANCE, with the possibility of some imperfection persisting. Furthermore, the result may not be the one I expected. I am aware that Medicine is not an exact science and as such nobody can guarantee results. I ACKNOWLEDGE THAT NO SUCH GUARANTEE WHATSOEVER HAS BEEN GIVEN TO ME.
6. I GIVE MY CONSENT to be photographed or filmed, before, during and after treatment, this material being a graphic diagnosis means and record for my medical background, belonging to the doctor. Furthermore, it may be published in scientific journals and books or shown for medical purposes.
7. I HEREBY GIVE or DO NOT GIVE MY CONSENT (delete as appropriate) for my photograph to be published in the DAILY PRESS or ORDINARY MAGAZINES. In any event, it is understood that in any use made of the same I shall NOT be identified by name.
8. I AGREE to the doctor delaying or suspending the peeling should he/she deem fit.
9. I UNDERTAKE to faithfully follow as far as I am able the doctor's instructions before, during and after the peeling. I UNDERSTAND this care must be followed exactly.
10. I HEREBY BEAR WITNESS I have neither overlooked nor altered data when describing my medical and clinical-surgical background, particularly in relation to allergies, illnesses or personal risks.
11. I have been able to settle all my queries regarding that set out above and have fully understood this DOCUMENT OF CONSENT, reconfirming each and every one of the 10 points above or WITH THE EXPRESS EXCEPTION (delete as appropriate) of that mentioned in point: _____

Date, Patient Name, Surname and Signature

Legal Representative (for patients under age) Name, Surname and Signature

Witness Name, Surname and Signature

I hereby declare all the blank spaces on this document were completed prior to the Patient or Authorised Representative and Witness signed the same.

Dr. _____
Name, Surname and Signature