

**REJUVENATION SPA OF ALPHARETTA**  
Christi Stowers Enterprises  
1380 Upper Hembree Road, Roswell, GA 30076

**SKIN TAG REMOVAL CONSENT FORM**

I, \_\_\_\_\_, understand that I will receive the following procedures: Cosmetic Skin Tag Removal using sterilized scissors.

My signature on this form authorizes the Licensed Esthetician at Christi Stowers Enterprises to perform the referenced procedure checked above.

1. I have been informed, to my satisfaction, regarding the nature of the procedure and acknowledge that this procedure is entirely a cosmetic procedure. I acknowledge that I have been medically cleared by my private doctor concerning this procedure and have previously addressed with my doctor any concerning lesions/moles on my skin. I acknowledge and understand that no staff member at Rejuvenation Spa will send any tissue for pathology analysis of any skin tag(s) removed today.
2. I have been informed to my satisfaction regarding the risks inherent in the performance of this procedure such as blood loss, infection, reaction to numbing cream (if applicable), scarring, or thickening of the skin where treated. Should an infection occur, I understand that medical treatment and/or antibiotics may be necessary from my private physician.
3. I understand that medical care requires my cooperation, and I will follow all post care instructions. If indicated I will make and keep appointments for follow up care and call the spa office to note any changes or concerns in my condition.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my complete satisfaction, and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

I understand there is no guarantee of results of any treatment. I understand regular charges apply to all subsequent treatments. I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I understand there are no refunds on any services rendered.

I release Christi Stowers Enterprises medical staff, technicians, and/or estheticians from liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_