Skin Rejuvenation Laser (IPL/IR/RF/Diode) Consent (Fotofacial, Refirme, Matrix IR)

As a patient, you will be provided with the opportunity to review your treatment with the medical professional responsible for your care before receiving treatment of any kind. You will be advised of the manner in which treatment will be provided, the risks involved and any alternative that is available for your consideration and will be given the opportunity to ask questions. By executing this form, you agree that the medical Aesthetician has reviewed treatment with you and answered your questions. Your attending medical Aesthetician will review this form with you a second time prior to your initial appointment and will sign this form in the space provided to indicate that you have been given a second opportunity to ask questions of a medical professional.

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

_____ I understand that to achieve maximum and continued results the protocol recommended by the medical Aesthetician should be followed.

_____ I understand that there are no guarantees implied as to the results of this treatment, due to many variables, such as: age, skin type, skin condition, sun damage, smoking, alcohol, environmental exposures, etc. I understand that I may or may not actually see demonstrable visual results, that each case is individual.

_____ I acknowledge that I have been candid in revealing any condition which might have an effect on this treatment, such as: pregnancy, medications, previous or recent skin surgery or treatment, skin cancer, cold sores/fever blisters, allergies, use of Retin-A, Accutane, Differen, or hormones.

_____ I understand that direct sun exposure is prohibited while I am undergoing treatment. The use of sun block protection with a minimum SPF of 30 is recommended. I agree to refrain from the skin tanning in tanning booths while I am undergoing treatment, and during the 14 days following my last treatment.

_____ If I am prone to herpetic outbreaks around the mouth, I have been advised to see my physician for a prescription of acyclovir or zovirax.

_____ I agree to refrain from any skin care treatment, cosmetic or medical, 14 days preceding and 14 days following any treatment including, but not limited to filler injections and Botox.

_____ I understand that I will not be allowed to have treatments during any pregnancy. My unused treatment fees will be refunded or the unused portion will be placed on hold.

_____I understand complications can occur, as with any laser treatment. On occasion, pain and
discomfort will occur with this procedure. Most of this can be treated with over the counter pain medication. Excessive pain during the procedure, especially during successive laser hair removal
procedures, should be brought to your health care providers attention immediately, so laser settings
can be adjusted. Other adverse events, although rare, are seen and should be reported immediately
to your health care provider. These include blisters and burns, and especially if there is a recent
history of sun exposure or if one goes into the sun immediately after the procedure. Avoid direct
sunlight for at least one week following laser hair removal procedures. Burns and blisters, can, on
occasion lead to either too much or too little pigment in the skin known as hypo- or hyperpigmentation.
Even rarer, true scarring can result with raised scars known as hypertrophic scars and keloids.
_____ I understand the laser is intended for skin rejuvenation and that clinical results will vary depending on individual skin types. I understand that there is a rare possibility of side effects such
as scarring and permanent discoloration as well as short term effects such as redness, swelling, mild
burning, temporary bruising, and temporary discoloration of the skin including hypo pigmentation
(decrease or lightening of skin color) or hyper pigmentation (increase or darkening of skin color).
These effects have been fully explained to me. As collagen degradation is a normal physiological
event, I understand that permanent wrinkle reduction is not possible without continued treatments.
For men, the laser treatment may reduce their beard hair in certain areas.
I have read and understand this agreement and all my questions have been answered and addressed
to my satisfaction. I consent to the terms of this agreement.

Printed name: _____

Signature: _____

Date: _____

I, the undersigned medical Aesthetician, hereby certify that I have reviewed the foregoing treatment
consent with the named patient (including the risks and alternatives to treatment) on or prior to the
first date of treatment and have given the patient the opportunity to ask questions regarding his or
her treatment, including the opportunity to communicate with a physician.

Medical Aesthetician _____

Date _____