DŌCERĒ

MEDICAL SPA & LASER CENTER

PIXEL ABLATIVE SKIN RESURFACING CONSENT

INITIAL_____ I UNDERSTAND THAT THE HARMONY PIXEL 2940NM ER:YAG IS A LASER SYSTEM DESIGNED FOR FRACTIONAL ABLATIVE SKIN RESURFACING AND THAT CLINICAL RESULTS MAY VARY IN DIFFERENT SKIN TYPES. I UNDERSTAND THERE IS A POSSIBILITY OF SHORT-TERM EFFECTS SUCH AS REDDENING, BLISTERING, SCABBING, TEMPORARY BRUISING AND TEMPORARY DISCOLORATION OF THE SKIN, AS WELL AS RARE SIDE EFFECTS SUCH AS SCARRING AND PERMANENT DISCOLORATION. I ALSO UNDERSTAND THAT ALTHOUGH INFECTION FOLLOWING LASER SKIN TREATMENT IS UNUSUAL, BACTERIAL, FUNGAL, AND VIRAL INFECTIONS CAN OCCUR. HERPES SIMPLEX VIRUS INFECTIONS CAN OCCUR FOLLOWING A LASER TREATMENT. THESE EFFECTS HAVE BEEN FULLY EXPLAINED TO ME.

INITIAL_____ CLINICAL RESULTS MAY VARY DEPENDING ON INDIVIDUAL FACTORS, INCLUDING MEDICAL HISTORY, AMOUNT OF SUN DAMAGE OR TEXTURAL PROBLEMS, SKIN TYPE, PATIENT COMPLIANCE WITH PRE/POST TREATMENT INSTRUCTIONS, AND INDIVIDUAL RESPONSE TO TREATMENT.

INITIAL_____ I UNDERSTAND THAT TREATMENT BY HARMONY PIXEL 2940NM ER:YAG SYSTEM INVOLVES A SERIES OF TREATMENTS AND THE FEE STRUCTURE HAS BEEN FULLY EXPLAINED TO ME.

INITIAL_____ I CERTIFY THAT I HAVE BEEN FULLY INFORMED OF THE NATURE AND PURPOSE OF THE PROCEDURE, EXPECTED OUTCOMES AND POSSIBLE COMPLICATIONS, AND I UNDERSTAND THAT THERE IS NO GUARANTEE THAT CAN BE GIVEN AS TO THE FINAL RESULT OBTAINED. I AM FULLY AWARE THAT MY CONDITION IS OF COSMETIC CONCERN AND THAT THE DECISION TO PROCEED IS BASED SOLELY ON MY EXPRESSED DESIRE TO DO SO.

INITIAL_____ I CONFIRM THAT I AM NOT PREGNANT AT THIS TIME, AND THAT I HAVE NOT TAKEN ACCUTANE WITHIN THE LAST 6 MONTHS. I DO NOT HAVE A PACEMAKER OR INTERNAL DEFIBRILLATOR. I ALSO HAVE COMPLETED A MEDICAL HISTORY CHECKLIST AND BEEN INFORMED ABOUT WHAT I MUST DO AND "NOT DO" BEFORE, DURING, AND AFTER THE SERIES OF TREATMENTS.

INITIAL_____ I CONSENT TO THE TAKING OF PHOTOGRAPHS AND AUTHORIZE THEIR ANONYMOUS USE FOR THE PURPOSE OF MEDIAL AUDIT, EDUCATION AND PROMOTION.

I CERTIFY THAT I HAVE BEEN GIVEN THE OPPORTUNITY TO ASK QUESTIONS AND THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS CONSENT FORM AND GIVE MY INFORMED CONSENT FOR PIXEL TREATMENT(S).

PATIENT SIGNATURE..... **DATE**.....

WITNESS..... **DATE**.....