

Skin Rejuvenation Informed Consent

Prior to receiving treatment, I have been candid in revealing any condition that may have a bearing on this procedure as outlined below. I will also inform the doctor of any changes in my medical history, current medications or skin care products prior to any future treatments.

Skin Rejuvenation is intended to improve the appearance of the skin. Rosacea, redness, skin damage, skin texture and irregular pigmentation can be improved by Skin Rejuvenation treatments.

The light wave length, time of exposure and energy level have been selected to target and treat specific areas to minimize damage to surrounding normal tissue.

Contraindications to treatment may include: pregnancy, use of medications that increase photosensitivity, insulin dependent diabetics, history of keloid scarring, use of anti-coagulants and history of bleeding disorder. Recent sun exposure or planned sun exposure is contraindicated.

Skin Rejuvenation treatments are a series of up to 5 treatments at 3 week intervals with gradual clearing occurring over this time. Clinical results may vary from patient to patient.

Permanent hair removal may be a side effect.

I understand that there is a possibility of a rare side effect such as scarring and skin discoloration, as well as common short term effects such as reddening, mild burning, blistering, bruising, and temporary discoloration of the skin. The side effects have fully been explained to me and all of my questions have been answered.

This procedure is considered cosmetic and as such is not covered by insurance. I understand I am responsible for all costs of treatment. I understand my responsibility of properly fulfilling the appropriate aftercare instructions as explained by the doctor and staff.

I have read and fully understand the terms within the above consent. All of my questions have been addressed to my satisfaction.

Patient's Name

Patient's Signature

Date

Witness Signature

Date