Plasma Pen Fibroblast Consent Form

I, ____ (patient name) Hereby authorize Advanced Skin & Vein Care Centers, to perform Fibro-blasting with the Plasma Pen on me. I understand that this procedure works on promoting skin tightening, lifting and rejuvenation by creating microtraumas to promote new collagen. I understand that multiple treatments may be needed and in rare cases no improvement may be seen. I am aware of the possible experience and or risks:

1. DISCOMFORT – some will be felt, varies patient to patient and area to area. _____(initial)

2. MILD TO MODERATE SWELLING – especially around the eyes and in the periorbital area. _____(initial)

3. STINGING SENSATION - for about an hour after treatment. ______ (initial)

4. TINY CRUSTS - form on the area treated and usually linger for 5-7 days. _____ (initial)

5. DO NOT PICK CRUSTS - This could cause scarring. _____ (initial)

6. AVOID SHAVING - in the area treated until all healing has taken place. _____ (initial)

7. AVOID HEAT FOR 3-4 DAYS (hot showers, exercise, etc.) _____ (initial)

8. NO SMOKING – this will hinder the healing process. _____ (initial)

9. IF POSSIBLE, TAKE VITAMIN C – it helps to boost your immune system. _____ (initial)

10. PRE AND POST CARE – I understand that I must comply with recommended pre and post care and following it is crucial for the healing, preventing infection and results of treatment. _____ (initial)

11. NO GUARANTEES – I understand that there are no guarantees and refunds will NOT be given. _____ (initial)

12. Hyperpigmentation – As a possible adverse reaction, I understand there is a risk of post treatment Hyperpigmentation. This would most likely be due to exposure of the area to UV light while the long-term healing process is taking place or the healing reaction of a client's skin. I understand I should use SPF40 sun protection for at least 12 to 20 weeks (from once the skin has healed several days after the initial treatment) as part of my aftercare program. _____ (initial)

13. Pink Atrophic spots (where the dots/spots were applied by Plasma Device) can last up to 6 months after treatment although this is incredibly rare. It is not completely clear what causes this long-term adverse reaction but, so far, this has ultimately subsided on its own in the long-term. It could be due to the use of make-up, other inappropriate products and/or poor personal aftercare during the short-term healing process. As a possible adverse reaction, I understand this is very rare but there is risk of this occurring after treatment. _____ (initial)

I attest that the following points have been made to me: ¬ The potential benefits of proposed treatments. ¬ The possible alternate procedures. ¬ The probability of success ¬ The most likely complications and risks involved with proposed treatments and healing period. My questions regarding this procedure have all been answered to my satisfaction I understand the procedure and accept the risks. I hereby release Advanced Skin & Vein Care Centers from all liabilities associated with the above indicated procedure throughout the treatment process. No guarantee, warranty, or assurance has been made to me as the results that may be obtained. I am aware that additional treatments may be necessary for desired results. Clinical results vary patient to patient, and I understand that. I agree to adhere to all safety precautions, pre and post care during treatments. I understand all payments are non-refundable.

ACKNOWLEDGEMENT: BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THE PERMISSION FORM FOR PLASMA PEN TREATMENTS AND THAT THE DISCLOSED HEREIN WERE MADE TO ME

Client Signature ____

Print Name ____

Date _____/_____/_____