Secret RF/CO2 Ablative Laser Consent

The following points of information, among others, have been specifically discussed and made clear to me and I have had the opportunity to ask any questions concerning this information.

**I confirm that I am not currently pregnant or nursing.
Initials:_____

**I confirm that I do not have an allergy to gold or metal, lidocaine, benzocaine and/or tetracaine.

Initials:_____

**I confirm that I have not had a face lift or upper/lower eyelid blepharoplasty within the last year. Date of surgery: _____
Initials:_____

**I confirm that I do NOT have a pacemaker, defibrillator, or any other electronic implantable devices.
Initials:_____

**After treatment, I understand that most patients will look as though they have a moderate to severe sunburn—more particularly with CO2 treatment, than microneedling RF. The skin could also feel tender to touch At times, patients will experience some swelling in the treated area. There is a greater chance of rough, sandpaper like texture to the skin and the possibility of a spot size pattern on the treated skin after a CO2 treatment. In rare cases, this could be permanent.
Initials:_____

**Microneedling RF and CO2 ablative laser may NOT be used on and may be contraindicated for any of the below conditions. I have disclosed any of the health concerns listed below. Please circle any that apply:

- Open sores or lesions
- Untreated skin cancer
- Broken or irritated skin, including such conditions as hives or dermatitis
- Any stage of melanoma on the area of proposed treatment
- Active acne
- Active Cold sores
- Any type of skin infections
- Auto-immune disorders

I understand that if any of the above health concerns are present at any of my treatments, I may be denied treatment and will be asked to reschedule. I also understand that it may be recommended to prophylactically treat any history of cold sores. Initials:_____

**I understand that I must wait at least 7 days after Botox and at least 28 days after any filler placement to have treatment. I also understand that if I have had a moderate facial peel, I must wait 28 days for treatment. And likewise, if I have had a deep facial peel, I must wait 3 months. Treatment prior to these time frames could result in unwanted distribution of Botox and inflammatory reactions could occur secondary to the other indicated cosmetic procedures.
Initials:_____

**I have disclosed and affirmed that I have discontinued Retin-A products, Vitamin A products, and/or topical acne medications at least 3 days prior to treatment. If applicable, I affirm that I discontinued Accutane a minimum of 6 months ago. Failure to do so could result in significantly more severe, pronounced and unwanted side effects. Initials:_____

**I understand that the procedure(s) is moderately uncomfortable and a topical numbing cream will be applied to the area to be treated. This will greatly minimize the discomfort, however, it cannot guarantee that the procedure will be pain free. Although very rare, there have been reports of lidocaine toxicity associated with topical use of Lidocaine. Initials:_____

**I understand the treatment of scars, whether accidental or surgical is NOT indicated if the scar occurred less than 6 months ago. To the best of my knowledge, I agree that I have disclosed an accurate time occurrence of the scar(s).
Initials:_____

**I have disclosed any bleeding/clotting disorders or current treatment with blood thinners, anti-platelet drugs and or anti-coagulants (other than aspirin). I understand that my treatment may be refused based on a specific review of the situation. Initials: _____

**I have been advised of the number of recommended treatments in order to achieve maximum benefits from the treatment(s). I understand that at times, scar tissue, stretch marks, deeper etched lines may benefit from additional treatments. I also understand that I cannot expect to see the same results with one treatment that I would see with a series of treatments, spaced appropriately apart. Initials:_____

**I have been instructed as to the recommended maintenance regimen following the treatment. I understand that intentional or incidental sun exposure on treated areas could result in hyperpigmentation (brown discoloration). I also have been informed that the treated area could become hypopigmented (lighter discoloration) after treatment and would typically be temporary, but on rare occasions, it could be permanent. I affirm that this has been disclosed to me as an associated risk inherent to the treatment. I understand that results of the treatment may

continue to be seen for several months after the last treatment (this statement is based on the assumption of a series of treatments). After this time frame, changes usually begin to plateau.

Initials:_____

**I have been informed of the following potential side effects following treatment:

- **Milia/acne**–this is more common in patients who are prone to acne, or have oily skin
- **Infection**–this is a possibility whenever the skin surface is disrupted, which could then lead to scarring. Although both possibilities are rare with these procedures, full disclosure of the risks have been made known to me.
- **Wounds**–Treatment can result in burning, blistering, or bleeding of the treated area. The treated area must not be picked or scratched, as this could lead to permanent scars or cause an infection**.**
- **Contact/Allergic Dermatitis**– There is a potential for increased sensitivity, irritation/itching or allergic reaction to the skin secondary to skin surface disruption.
- **Petechiae**– Pinpoint broken blood vessels can occur during/after treatment; these will resolve without any treatment; a greater probability of this side effect occurs with concomitant use of ibuprofen, aspirin, or blood thinners.
- **Dilated Pores**– Collagen contraction that occurs as part of the resurfacing process may also contract the skin between the pores, which widens the existing pores. This occurrence, though rare, is permanent.

Initials: _____

**I understand that photographs will be taken prior to treatment and used for procedure evaluation. I understand that these pictures will be maintained as confidential, unless prior authorization has been given, to use for medical educational purposes. Initials: _____

**I have been informed of the financial agreement in regards to consultation fee, cost of procedure(s), required deposit and cancellation policy. Initials:_____

**By my signature below, I confirm that I have read and answered all questions to the best of my knowledge and understand that withholding necessary information about my health and medication may increase my risk of possible side effects.

Patient Signature: _____ Date_____

Print Name:

_____

Witness Signature: _____ Date:_____