Dr. R. van Aardt
Cosmetic Medicine

CONSENT FOR PIXEL LASER SKIN RESURFACING

Date: _______________

Name: ____ Date of Birth: _________________

Treatment sites:

Please initial and sign below:

_____ I voluntarily consent and authorize the use of the Harmony Pixel 2940nm Er:Yag system to perform fractional ablative skin resurfacing and any post treatment medical requirements that may be necessary by a Certified Service Providers at this Medi Spa as deemed necessary.

_____ I hereby release this clinic, its staff, and any other participating health care providers from any and all liability for any adverse effects that may result from this treatment and related procedures.

_____ I understand that the Harmony Pixel is a laser device designed for fractional ablative skin resurfacing and that clinical result 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. These effects have been fully explained to me.

_____ 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. I understand that treatment by the Harmony Pixel 2940nm Er:Yag system involves a series of treatments and the fee structure has been fully explained to me.

_____ I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, I understand that no guarantee 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.

_____ 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.

_____ I consent to the taking of photographs and authorize their anonymous use for the purposes of medical 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.

_____ If I have forgotten to tell the clinic staff of my health problems, medications, allergies or other important information about me, I will do so now. I will inform the staff if I become pregnant.

_____ I confirm that I have received post-care information regarding this treatment.

By signing below I hereby consent to the treatment and my signature shall serve as my consent to future treatments. I understand that any skin or medical treatments are not an exact science and that results may vary from person to person. I understand that this Medi-Spa is physician supervised and that should I have any concerns I will contact them.

______________________	______________________	____________
Print Name of Client	Signature of Client	Date
______________________	______________________	____________
Print Name of Service Provider	Signature of Service Provider	Date