PLEXR Ablative Treatment Consent

JOHNSONS Family Medicine

Please read and initial each of the statements below:

_____ I certify I am over the age of 18 and understand that I have chosen to electively undergo this procedure.

_____ I understand that plasma fibroblast is an art process and not an exact science. Therefore, an exact shrinkage result cannot be guaranteed due to skin elasticity and the individual healing process.

_____ I understand that I may be required to return for additional treatments before my overall procedure is deemed complete. The payment for any additional work, (if applicable), will be agreed upon prior to the treatment commencing. Depending upon the area of treatment, additional treatments cannot be performed until after 4-8 weeks from the date of initial treatment in order to allow the initially treated area to heal fully.

_____ I understand that my practitioner will use a treatment plan to record the areas I have chosen, topical anesthetic used, the probe used, as well as pre-and post-treatment photographs. This information will be held securely in my consultation record.

_____ I understand that the skin type of every client is different and the healing process may lead to some discoloration of the skin.

_____ I understand that after each treatment, some swelling or redness may occur. In some cases, there may be extreme swelling. My practitioner will give me appropriate advice to help reduce this risk. Throughout the treatment, I may experience some discomfort, but my practitioner will do what they can throughout my treatment to make me feel as comfortable as possible.

_____ I understand that since the treatment includes small burns to the skin, I may experience a slight burning smell which is normal. A smoke/vapor eliminator will be used during the procedure.

_____ I understand that I must adhere to the practitioner's aftercare advice given to me following my treatment. This is very important and will reduce the risk of post-procedural infection upon leaving the clinic.

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_____ I understand that I must let the treated area heal properly. I agree to avoid picking, plucking, or scratching as this will hinder the healing process and could make the treatment appear uneven thus requiring further work.

_____ I am aware that skin altering procedures such as plastic surgery, implants, injectables, and weight gain may alter the fibroblast look.

_____ I have been informed of possible benefits, risks, and complications, and I have had the opportunity to ask questions regarding these risks and other possible complications.

_____ I have, to the best of my knowledge, given an accurate account of my medical history, including all known allergies or prescription drugs or products I am currently ingesting or using topically.

_____ I consent to photographs being taken BEFORE, DURING, and AFTER my procedure. I agree to these being stored with my case file and used for promotional purposes.

I understand that my practitioner will be in direct contact with me in relation to the fibroblast treatment. This treatment involves the use of a disposable probe and other equipment that is sterilized before use. I understand that all surfaces involved in the process are protected, and gloves will be worn at all times by the practitioner during the treatment. I hereby consent to receive a fibroblast treatment. My practitioner has explained the terms and conditions of the treatment and I have fully understood these.

I hereby give written consent to the esthetician to carry out the treatment of my choice as requested by me on this consent and treatment agreement.

_____	_____	_____
Patient Name	Signature	Date
_____	_____	_____
Provider Name	Signature	Date