



# Consent for Surface Power

# 2 Fotofacial

I authorize Surface Medical Spa personnel to this treatment upon me to attempt to reduce or eliminate sun damage, actinic keratosis, unwanted pigment, vascular lesions, and wrinkles. This treatment may also be used for hard-to-treat acne. I understand that this procedure is purely elective and that the goal of this procedure is improvement, not perfection.

I understand that the results depend upon numerous factors, including skin color and sun exposure. There may be more treatments than anticipated to achieve the desired result. Intense light may cause eye damage unless protective eye wear is worn during treatment.

Common side effects include; peeling, redness and dark spots, swelling, tenderness, “sunburn” like effects that may last up to 5 days or longer. Pigment changes (light or dark spots on the skin) lasting 1-6 months could occur. Freckles may temporarily or permanently disappear in treated areas. Other potential risks include: crusting, itching, pain, bruising, burns, infections, scabbing, scarring, swelling, and failure to achieve the desired or expected results. I understand that serious complications are rare but possible.

I understand that sun or tanning lamp exposure after treatments and not carefully adhering to the post-care instructions provided will increase my chances of complications.

I consent to photographs being taken to evaluate treatment effectiveness, for medical education, training, professional publication, promotional and sales purposes. These photographs may be used and displayed publicly without my permission. I understand full-face photographs revealing my identity will not be used without my written consent.

Pre and post treatment instructions have been discussed with me. The procedure, as well as potential benefits and risks have been explained to my satisfaction. I have had all of my questions answered and freely consent to the proposed treatments.

By signing this consent I certify that I do not have;  
a history of keloid or hypertrophic scar formation, active infections/immunosuppression, open lesions, Herpies I or II, Tretinoin (Retin-A, Renova), oral isotretinoin/Accutane.

Patient Signature \_\_\_\_\_ Witness Signature \_\_\_\_\_

Print Name \_\_\_\_\_ Print Name \_\_\_\_\_

Date \_\_\_\_\_ Date \_\_\_\_\_