Consent for Fotofacial

I authorize Surface Medical Spa personnel to this treatment upon me to attempt to reduce or eliminate unwanted pigment and/or vascular lesions. I understand that this procedure is purely elective and that the goal of this procedure is improvement, not perfection.

I understand that the number of treatments necessary depend upon numerous factors, including skin color and sun exposure. Multiple treatments will be necessary to achieve the best results. 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.

I understand that serious complications are rare but possible. Common side effects include temporary redness and mild "sunburn" like effects that may last up to 3 days or longer. Pigment changes (light or dark spots on the skin) lasting 1-6 months could occur. In addition, 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.

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.

I understand that sun or tanning lamp exposure after treatments and not 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.

Patient Signature ______________________ Witness Signature ______________________

Print Name ______________________ Print Name ______________________

Date ______________________ Date ______________________