INFORMED CONCENT FOR PHOTOFACIAL/SKIN REJUENATION and/or NON- ABLATIVE WRINKLE REDUCTION/ Fractional CO2 Laser

I _____, consent to and authorize INK ON INK OFF and members of its staff/ personnel to perform treatments on me. Light can be used effectively to destroy targets located in the skin with minimum damage to the surrounding tissues. Light is used to lighten, fade or remove photo-damaged skin in a non-ablative manner, a procedure known as facial revitalization. Visible signs of photo damage include wrinkling, enlarged pores, course skin texture, and pigment alterations.

Photo-therapy, despite its high levels of efficacy and safety, is not free of side effects. Erythema (redness) and edema (swelling) of the treated area can occur but usually subsides within a few hours but can last up to seven days or longer. Irritation, itching, and/or mild burning sensation or pain similar to sunburn may occur within 48 hours of treatment.

Pigmentary changes such as hyper pigmentation and hypo pigmentation of the skin in the treated area can occasionally occur. Mostly it is transient, lasting up to six months, but in the rare cases it can be permanent. Most cases of hypo or hyper pigmentation occur in people with darker skin or when the treated area has been exposed to sunlight before or after treatment. Occasionally these pigmentary changes occur despite appropriate protection from the sun.

Scarring, which can be hypertrophic or even keloid, can occur. Other known complications of this procedure include blisters, reddening, pinpoint pitted scars, bruising, superficial crusting, burns pain, and infections. These side effects are usually temporary, lasting from five to ten days but can be permanent as well.

The skin at or near the treatment site may become fragile. If this happens, makeup should be avoided and the area should not be rubbed, as this might tear the skin. a blue-purple bruise may appear on the treated area, which might last from 5 to 15 days. As the bruise fades, there may be rust-brown discolorations of the skin, which fades in one to three months or longer.

Additionally, there is a known and expected loss of hair in the treated areas. In a very small percent of people there is new hair growth in the surrounding areas being treated.

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Even though appropriate measures are taken to reduce side effects, they cannot be completely eliminated in every case. I understand that the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks. There may be other treatment options, such as injections, other types of lasers/light sources or peels. With this in mind, I am choosing this non-invasive treatment for vascular and/or pigment lesions and other indicated skin conditions.

Eye damage can occur from the light and therefore protective eyewear must be worn during all phototherapy sessions.

I have read and understand the Pre and Post- Treatment Instuctions. I agree to follow these instructions carefully. I understand that compliance with recommended pre and post procedure guidelines are crucial for healing, prevention of scarring, and other side effects and complications such as hyper pigmentation, hypo pigmentation, and other skin textural changes.

I understand that this examination is not meant to replace the necessity for a complete dermatological examination.

Photographs: I give permission for my photographs to be used to help document my treatment course. Complete confidentiality will be maintained.

No guarantee, warranty, or assurance as been made to me as to the results that may be obtained. I am aware that follow-up treatments may be necessary for desired results. Most patients require a number of treatments over several months with gradual results occurring over this time. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for treatments received.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

I release the physician(s) and/or any other INK ON INK OFF personnel, medical staff, and specific technicians from liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

NOTE: all prices are subject to change without prior notice.

Client/ Guardian Signature _____Date: _____

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