Portrait® PSR3: Plasma Skin Regeneration

Informed Consent Form

To the CLIENT: You have a right to be informed about your condition and its treatment, so that you may decide whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give, or withhold, your consent for treatment.

1. I ___________________________understand that I will be treated using the Portrait® PSR3 device.

2. Portrait® PSR3: Plasma Skin Regeneration is a non-ablative procedure that reduces facial wrinkles, superficial skin lesions, Actinic Keratoses (dry, scaly, rough-textured patches or lesions) on the face by using nitrogen gas plasma which remodels collagen and reduces wrinkles.

3. I understand that multiple treatments are necessary to achieve desired results. Treatments tend to last approximately one year. Touch up treatments may be necessary to maintain desired results. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. 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.

4. **Possible Side Effects can include but are not limited to**: Redding/browning of treated skin until top layer sheds (can take 3-5 days), swelling, bruising or blistering.

5. I understand this treatment can reduce the appearance of wrinkles but will not correct underlying cause.

6. I am aware and understand that my technician may use topical numbing cream, anesthetic nerve block, or oral pain medication which may be recommended based on the level of treatment I have elected.

7. I understand it is imperative I advise my technician if I have had any dermal fillers or other cosmetic treatments within the last year or if I am planning those treatments in the next year.

8. I have read and understand the Pre and Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre and post procedure guidelines are crucial for healing, prevention of side effects and complications as listed above.

I understand and agree that all services rendered to me are charged to me directly 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_________________________, medical staff, and specific technicians from liability associated with the 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's Name (Please Print):____

Client's Signature:____

Date:_______________________________ Time:_______________________