



METROPOLITAN
ANTI-AGING • BEAUTY • WELLNESS

Name _____

Date of Birth _____

LASER NON-SURGICAL FACE LIFT CONSENT FORM — ABLATIVE —

I understand that the ablative non surgical laser facelift consists of Three (3) technologies:

-Accent XL a radio- frequency (RF) devise intended for use in dermatologic and non-surgical procedures for non- invasive skin tightening, body contouring, cellulite reduction, and treatment of wrinkles and rhytides. The result of Accent treatments has demonstrated improvement in the smoothness and laxity of the skin.

-IPL (intense pulsed light) Laser is used for skin rejuvenation to partially reduce or eliminate signs of photo(sun) damaged/aged skin, redness , capillaries, and dark spots. The results of IPL treatment demonstrates improvement in smoothness and clarity of the skin.

-Pixel Laser is used for fractional ablative skin resurfacing to reduce or partially eliminate signs of photo damaged/ aged skin, skin tags, facial wrinkles, or reduce scarring from skin conditions such as acne. Generally, the results of Pixel treatments demonstrate improvement in smoothness and texture of the skin; however, a complete elimination of all laxity,photo damaged skin, all wrinkles or scarring is not a realistic expectation

Please initial next to each item:

_____ I understand that treatment by the Laser Non-Surgical Facelift involves a series of treatments to achieve optimum results and the fee structure has been fully explained to me. The fee is for the series of treatments purchased and includes post treatment follow-up visits. There will be a charge for any additional treatments. Life time touch-ups are offered at 50% off the area treated when a package of three (3) or more sessions are purchased.

_____ Services purchased are non refundable unless the Metropolitan is unable to perform the treatment(s).

_____ I understand clinical results may vary depending on individual factors, including medical history, skin type, patient compliance with pre/post treatments instructions, and individual response to treatment.

_____ I understand the practice of laser therapy is not an exact science and I acknowledge that no guarantees have been made to me concerning the results and procedure. It is not possible to state every complication that may occur as a result of the laser treatments

_____ I understand the downtime with ablative pixel can be a few days to a few weeks based on a variety of individual factors. I have consulted with my laser technician and understand the range of down time based on my Pixel Laser test spots and the recommended treatment plan.

_____ I am aware that the effects of the treatment vary by individual and adequate hydration is essential for positive results.

_____ The treatment may be uncomfortable, but is normally managed without any pain medication. My technician will work with me on pain management if needed.

_____ I understand and agree that topical anesthetics may be used by my technician for pain control during my treatments.

_____ I understand there is possibility of short term (few seconds to hours) of adverse effects such as a heating sensation, erythema (redness) and dry skin.

_____ I have been candid in revealing any new or existing condition(s) that I may have, which may affect the outcome of this procedure.

_____ I understand that exposure to the sun is contraindicated. Exposure to the sun encourages skin pigment changes and rhytids (wrinkles) necessitating further treatment. **St James SPF 30 Sunscreen** must always be used.

_____ **I confirm that I am not pregnant at this time.**

_____ **I have not taken Accutane within the last 6 months.**

_____ **I confirm I have been candid with my technician of any history of seizures or epilepsy and understand that laser emitted light could trigger a seizure. Additional precautions may be taken by my technician.**

_____ **I confirm that I do not have an implantable pacemaker or automatic defibrillator.**

_____ **I confirm that if I have any metallic pins or implants including metallic dental implants they are listed below:**

List all Implants: _____

_____ I understand and agree that photographs will be taken before and after each procedure(s).

CONTINUE FORM ON BACKSIDE (PAGE 2)

Please initial next to each item:

Although complications are infrequent following laser treatments, I understand the following short term side effects or complications may occur or are theoretically possible and could happen to me:

- _____ Loss of freckles (pigmented lesions) may occur.
- _____ If you are being treated for pigmented lesions, it is possible a “peppering” or darkening of the lesion could occur. These lesions normally “crust” and typically shed in 7 to 10 days.
- _____ Blistering, bruising, or scabbing is possible but uncommon and should resolve within a few days. Additional treatment may be needed. (see the Pre and Post Treatment Care information supplied to you)
- _____ Pain—Minimal discomfort if any, a burning sensation or very mild pain in the first few hours after the procedure.
- _____ Redness—or a “hot” feeling, inflammation and swelling are normal and should resolve within a few hours to a few days.
- _____ Wound Healing—light flakiness of the treated area may occur 2-7 days after treatment.
- _____ Skin Thickening—Textural changes of the treated skin, such as skin thickening, which may persist for a variable time.
- _____ Skin Tightness—Sensation of skin tightness (peaks at 3-8 weeks post treatment).
- _____ Occurrence or recurrence of **Herpes Simplex Dermatitis (cold sores)** particularly if not pre-, intra- and post-treated with a Systemic antiviral medication such as Zovirax. Please inform your technician of symptoms and if needed medication will be prescribed.
- _____ Skin Itchiness—Pruritis or itching in the early healing phase. Use St James Ultra Calm to soothe and relieve itching.
- _____ Hyper/Hypopigmentation—Color changes such as hyperpigmentation (brown/red discoloration) or hypopigmentation (skin lightening) may occur in treated skin, especially in darker skinned people. This may take several months to resolve, if at all.

I have been candid in revealing any existing or new conditions(s) that I have. My technician has explained the Laser Non-Ablative Facelift to me and I have been asked at this time whether I have any questions and I do not. I have been given a copy of pre and post treatment instructions and have consented to abide by the instructions. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. I understand the procedure, risks, benefits and alternatives. I accept the risks and request that Pixel laser treatments be performed on me by a qualified technician. I hereby release my technician and The Metropolitan Clinic, LLC from all liabilities associated with the above indicated procedure.

Client Signature _____ Date _____

Technician Initials _____ Date _____