METROPOLITAN
ANTI-AGING • BEAUTY • WELLNESS

Name _____

Date of Birth _____

LASER NON-SURGICAL FACE LIFT CONSENT FORM
— NON-ABLATIVE —

I understand that the **Laser Non-Ablative Non-Surgical facelift** consists of **three** (3) technologies:
-Accent XL is a radio-frequency (RF) device for use in dermatologic and non-surgical procedures for non-invasive skin tightening, body contouring, cellulite reduction and treatment of wrinkles and rhytides. The results 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 treatments has demonstrated improvement in the smoothness and clarity of the skin.
-ClearLift laser is used for fractional non-ablative skin resurfacing to reduce or partially eliminate signs of photo damaged/aged skin, facial wrinkles or reduce scarring from conditions such as acne. The results of ClearLift treatments has demonstrated improvement in smoothness and texture of the skin. However, a complete elimination of all laxity, photo damaged/aged 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 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 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 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 belo**w:
List all Implants:_____
_____
_____
_____ I understand and agree that photographs will be taken before and after each procedure(s).

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.

Continue form on backside (page 2)

Please initial next to each item:

_____ 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)
_____ 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.
_____ Textural changes of the treated skin, such as skin thickening, which may persist for a variable time.
_____ 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) in the early healing phase. Use St James Ultra Calm to soothe and relieve itching.
_____ Color changes such as hyperpigmentation (brown/red discoloration) or hypopigmentation(skin lightening) may occur in, especially in darker skin. This may take several months to resolve, if at all. These complications are almost always caused by sun exposure before or after treatments, therefore **sun exposure is contraindicated** and **St James SPF30 Sunscreen** must always be used.
_____ Eye injury is possible but unlikely, provided the supplied eye protection is properly used as instructed during the laser treatments.

I have been candid in revealing any existing or new condition(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 _____