METROPOLITAN
ANTI-AGING • BEAUTY • WELLNESS

Name _____

Date of Birth _____

LASER PIXEL CONSENT FORM

I understand that Pixel laser is used for fractional ablative skin resurfacing to reduce or partially eliminate signs of photodamaged/aged skin, skin tags, facial wrinkles or reduce scarring from skin conditions such as acne. Generally, the results of Pixel treatments demonstrate improvement in the smoothness of the skin; however, a complete elimination of all wrinkles or scarring is not a realistic expectation.

Please initial next to each item:

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

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

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

_____ Pain—Minimal discomfort if any, a burning sensation or very mild pain in the first few hours after the procedure. A local anesthetic is usually not used during the treatment, but some degree of discomfort may appear after the procedure and this pain may persist for several hours to a few days.

_____ Redness—or a "hot" feeling, inflammation and swelling are normal and should resolve within a few hours to a few days.

_____ Wound Healing—Flakiness of the treated area, usually persisting for 2-7 days.

_____ 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. 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 during laser treatments.

I have been candid in revealing any existing or new condition(s) I have. My technician has explained Pixel laser fractional ablative skin resurfacing 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 _____