ADVATx®

TREATMENT INFORMED CONSENT

PATIENT CONSENT TO TREATMENT

My signature below constitutes my acknowledgement that:

1. I,__________________________ consent to and authorize ___________________ and staff members to perform laser-assisted skin care treatments and related services on me.

2. The nature and purpose of the treatment have been explained to me and any questions I have had regarding the treatment have been answered to my satisfaction.

3. I acknowledge that I have revealed any current or previous condition that may affect the outcome of the treatment (including but not limited to Photosensitive condition, auto-immune deficiency, herpes, pregnancy, hormonal disease, allergies, etc.) and that I have revealed any use of medications (including but not limited to anti-coagulants, Rogaine®, etc.).

4. I understand that the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks. Possible side effects of the area treated can include mild redness of the skin, irritation, local swelling, mild discomfort or tenderness, pinpoint bleeding, bruising, pimple like bumps, lightening or darkening of the skin and a small risk of scarring.

5. I understand that I have the right to refuse treatment.

6. Due to the nature of this treatment, exact results cannot be predicted, and I acknowledge that no guarantees have been made to me as to the results that may be obtained. I further understand that no promises of permanence have been made to me regarding any laser or skin care treatments.

7. I certify that I have read this entire informed consent and that I understand and agree to the information provided orally and in this form. I certify that I am a competent adult over 18 years of age. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relative, legal representatives, heirs, administrators, successors and assigns.

8. I agree to adhere to all safety precautions and regulations during the laser treatment.

9. I have received and understand post treatment skin care recommendations.

10. I agree to pay $_________ for the above-mentioned services and understand that there will be no refund for any performed services.

PATIENT SIGNATURE: ____________________________________ **DATE:** __________________

FOR PROVIDER COMPLETION:

The undersigned hereby certifies that he/she discussed with the above-named person all the foregoing matters, including the risks and benefits of the treatment and that the discussion in his/her judgment was adequate and reasonable. In addition, the patient was encouraged to ask questions and all questions were answered.

SIGNATURE: ____________________________________ **DATE:** __________________

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LASER CONTRAINDICATIONS

- ☐ Pregnant
- ☐ Have any type of infectious disease
- ☐ Have Lupus or Rheumatoid Arthritis
- ☐ Are on long-standing systemic steroids such as Prednisone
- ☐ Have used isotretinoin (Accutane) in last 6 months
- ☐ Any uncontrolled autoimmune disorder, diabetes or any infectious disease, such as HIV, that could impair the body's healing process
- ☐ Have a medical condition that may affect wound healing

POSSIBLE COMPLICATIONS

Complications, although rare, occasionally occur and should be discussed and understood. The patient must understand the importance of post care instructions and that failure to comply may increase the probability of complications, which could include:

- ☐ Scarring-hypertrophic any non-hypertrophic
- ☐ Burns
- ☐ Hyperpigmentation
- ☐ Hypopigmentation
- ☐ Induced bruising or petechia formation
- ☐ Edema
- ☐ Wound infection

Patient signature:______________________________ Date:______________________________

If any of the above contraindications apply, you should NOT proceed with the ADVATx treatment.

For any questions or concerns regarding the treatment or contraindications, please contact your Reveal Clinical Educator directly or email clinical@reveallasers.com

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AdvaTx Post Care Instructions

1. No hot tubs, saunas, hot showers, strenuous exercise, or spicy foods for 24 hours.
2. Do not use/apply AHAs, BHAs, Retin-A's or Renova for 72 hours post treatment.
3. Avoid direct extended sun exposure for 72 hours. An SPF 30 or higher should be worn every day even when you are not actively in the sun.
4. Because the laser has sterilized your skin, it is not necessary to cleanse the night of your treatment. However, if you must cleanse, use a gentle cleanser and continue to use a gentle cleanser for 72 hours post treatment before returning to normal skincare regimen.
5. If redness or sensitivity occur, wash your face with cool water and apply a cool compress or ice pack to the area. If sensitivity continues for more than 12 hours, contact your physician or skincare provider.
6. If you are prone to fever blisters (oral herpes), ask your physician/provider for a prophylactic prior to treatment.
7. Never pick or peel treated skin, as this can cause scarring and/or discoloration.
8. Keep skin well hydrated by drinking lots of water and using appropriate moisturizers for your skin.