Plasma Fibroblast Consent Form

_____ _____

Patient's Name **Date**

Please initial each paragraph after reading. If you have any questions, please ask your technician BEFORE initialing.

_____ **I have chosen a procedure that is not medically necessary. This is an elective, cosmetic procedure and I understand that results may vary due to individual patient differences I realize there can be no guarantee that the proposed treatment will be curative (healing) or meet all aesthetic (sense of beauty) expectations.**

_____ **Plasma fibroblast therapy is an aesthetic procedure which healthcare providers offer as an alternative to laser, injections, or surgical therapies to tighten and improve the appearance of skin. Plasma fibroblast therapy targets fibroblasts. These are collagen– and protein-producing cells in the dermis, the layer of skin just below the outermost skin layer. Fibroblast is not an exact science and cannot guarantee results due to each individual's skin type, elasticity and healing process.**

____ **Fibroblast will neither stop the aging process nor totally eliminate wrinkles. The final result of treatment may not be apparent for several months. Future treatment may be necessary, depending upon the success of this initial treatment. Depending on the area(s) treated, additional treatment(s) cannot be performed until after 4 – 8 weeks from the initial treatment date.**

_____ **Treated areas will have redness and swelling which may last for 7 to 10 days. In some cases there may be extreme swelling. Your technician will give you appropriate advice to help reduce swelling and relieve any discomfort. At the junction between treated and untreated areas, a different skin color or blotching may occur. Deep areas of skin wrinkling may be minimized or softened, but not eliminated. Discoloration may occur so Microdermabrasion or skin rejuvenation may be advised. The risk of infection is rare, but should it occur, topical and/or systemic antibiotic therapy may be necessary.**

Plasma Fibroblast Consent Form

____ **I have provided a full and truthful health and social history, including drug, alcohol and tobacco use. I understand that withholding information may delay healing and jeopardize the planned goals. I agree to cooperate fully with my technician's recommendations while under treatment, realizing that lack of cooperation can increase risks and complications.**

____ **I agree to avoid direct sunlight for three (3) months after treatment and to use sun block of at least SPF 30 for 6-12 months thereafter. I also agree to decrease alcohol and tobacco use as much as possible, recognizing their negative effect on healing.**

___ **I consent to the taking of photographs being taken BEFORE, DURING and AFTER my procedure. I agree to these being stored with my case file and used only with my written consent for promotional purposes.**

CONSENT

I certify that I have had an opportunity to read this entire consent, that all blanks were filled in before my signing, and that all my questions were answered to my satisfaction. I also certify that I speak, read and write English. My signature below indicates my understanding of my proposed treatment and I hereby give my willing consent to the procedure.

_____

Patient's Signature

_____

Technician's Signature