INFORMED CONSENT

Patient Name: _____

Date of Birth: _____ Gender: [__] Male [__] Female

[Please complete the information above]

Instructions

This Informed Consent is designed to provide you with information about Photopneumatic™ treatment procedures for the removal of unwanted hair, skin rejuvenation (benign vascular and pigmented lesions), and acne using the PPx™ and Isolaz™ Systems, including potential side effects and risks of treatment.

Please take the time to carefully and fully read this Informed Consent. If you understand and agree to the contents of this document and consent to the proposed treatment, please date and execute this Informed Consent on the last page. If you have any questions or concerns, you should discuss them with _____ prior to signing this document.

Consent to Release of Medical and Treatment Records

I hereby consent to the disclosure of my medical and treatment records related to my treatment (including all photographs taken to document and track my treatment) for use by third parties solely on a de-identified basis (i.e., with all personal identifying information removed).

	Yes	**No**
_____	☐	☐

[Please initial to indicate consent]

Medical History Disclosure

I understand that _____ has asked me to complete a [Patient Medical History] form. If there are any Issues that are not covered by the [Patient Medical History] form which I think are relevant to my treatment, I will inform _____ prior to treatment.

I will also notify _____ of any changes in my health or medical care as they occur during my treatment program. In addition, I will inform _____ of all medications, drugs and other products that I currently take or commence taking during treatment, including, but not limited to, prescription medications (including birth control pills), over-the-counter medications, herbs, supplements and vitamins. I understand that any failure to do so on my part may affect the results of my treatment and/or increase the likelihood of side effects or post-treatment complications.

Description of the Procedure

The PPx™ and Isolaz™ Systems use Photopneumatic™ technology (i.e., pneumatic (vacuum) energy and broadband light) to treat the following:

Hair Removal - The PPx™ and Isolaz™ Systems can be used to remove unwanted hair.

Skin Rejuvenation - The PPx™ and Isolaz™ Systems can be used to treat benign vascular and pigmented lesions.

Acne – The PPx™ and Isolaz™ Systems can be used to treat mild to moderate acne, pustular acne, comedonal acne, mild to moderate inflammatory acne and acne vulgaris.

Both Systems utilize a treatment tip that applies gentle vacuum pressure to draw the area to be treated into the handpiece of the System. This "pulling up" motion brings the treatment targets (for example, unwanted hair, vascular or pigmented lesions or acne) closer to the surface of the skin. Broadband light energy is then applied to the targets. The light energy is then converted to heat energy and absorbed by the targets, thereby destroying the targets.

Potential Side Effects and Risks

I understand that there are potential side effects and risks associated with my treatment. I understand that these include, but are not limited to, pain, scarring, bruising, swelling, redness, purpura, blistering, hyperpigmentation and hypopigmentation. I can minimize these side effects and risks by strictly adhering to the post-treatment care instructions given to me by the staff at _____.

I also understand that the light-based technology used in the PPx™ and Isolaz™ Systems creates a potential risk of eye damage. To minimize this risk, _____ will provide me with appropriate protective eyewear for my use during treatment.

Results Not Guaranteed

I understand that the results of my treatment cannot be guaranteed. I understand that my results may vary based on the following factors: skin type, area of body being treated, natural hair color, post treatment care, follow-up care and tanning by sun-exposure or self tanning products. I understand I may require multiple treatments in order to obtain the desired results. In order to obtain the best results, I will strictly adhere to the post-treatment care instructions given to me by the staff at _____.

Informed Consent

I understand that this Informed Consent shall remain in effect as long as _____ continues to provide me with the treatments described in this document.

By signing below I acknowledge and agree that:

- I have read, fully understand and agree to the contents of this Informed Consent;
- The treatments described in this Informed Consent and the potential side effects and risks have been satisfactorily explained to me;
- I have been given an opportunity to ask any questions that I might have, and all of my questions have been answered to my satisfaction; and
- I hereby give my voluntary informed consent to the performance of the treatment(s).

_____	_____
Patient Signature	Witness Signature
_____	_____
Patient Name (please print)	Witness Name (please print)
_____	_____
Date (please print)	Date (please print)

If the patient is under the age of 18, a parent or legal guardian must sign below:

_____	_____
Parent/Legal Guardian Signature	Witness Signature
_____	_____
Parent/Legal Guardian Name (please print)	Witness Name (please print)
_____	_____
Date (please print)	Date (please print)