Informed Consent: Aesthetic Fotofacial/BBL/Skin Rejuvenation

Client Name: _____

I hereby authorize and direct A Little Skin Studio, LLC and its associates to treat me with laser, radiofrequency and/or other light-based therapies to perform aesthetic photo rejuvenation. I specifically acknowledge that no guarantees or warranties have been made concerning the results of the treatment(s). The following statements have been discussed with me prior to procedure. I have had the opportunity to ask questions and have received appropriate and satisfactory answers.

I understand that:

____ **Fotofacial/BBL/Skin Rejuvenation** (Photo Rejuvenation) is an elective procedure and not considered a medical necessity.

____ The most common and potential complications of **Fotofacial/BBL/Skin Rejuvenation** and the subsequent healing process include scarring, blistering, skin discoloration, hypo-pigmentation (lightening of the skin), and hyper-pigmentation (darkening of the skin). Should any of these occur, they are usually temporary and can resolve in a few days or weeks, but certain skin discolorations may be permanent. Careful adherence to both pre and post-**Fotofacial/BBL/Skin Rejuvenation** instructions will greatly help in minimizing these risks.

____ Visible striping may occur with initial treatments, especially for areas with greater sun damage. Overall evenness of the skin will improve with subsequent treatments. Striping rarely occurs on the face and neck, but is more likely when treating arms, legs or chest.

____ Discomfort may be experienced during the laser treatment. Topical anesthetic is available which may lessen the discomfort. Instructions for topical anesthetics must be strictly adhered to in order to avoid complications. Specifically, I must avoid any procedures that would increase absorption of the anesthetic, such a wrapping with gauze or plastic.

____ I understand that eye protection must be worn at all times during treatment.

____ **Fotofacial/BBL/Skin Rejuvenation** is not expressly contraindicated during pregnancy or nusing. If I am breastfeeding or pregnant, I will seek the advice of my physician before undergoing any Photo Rejuvenation treatments. I understand that it is my responsibility to inform A Little Skin Studio, LLC if I am nursing or pregnant.

____ I authorize A Little Skin Studio, LLC and its associates to take pictures of treated area(s) only to be stored in my patient file and/or used for advertising purposes. I understand that this information will otherwise be kept confidential and that my identity will not be revealed to anyone

other than the aesthetician responsible for my treatments, A Little Skin Studio, LLC medical director and personal physician.

____ I understand that any deposits are non-refundable unless I cancel my appointment at least 24 hours prior to the first scheduled procedure. I will be charged $50 for any appointments not kept without providing a 24 hour notice of cancellation.

____ I understand that A Little Skin Studio, LLC carries professional liability insurance covering the company, its staff, its medical director, and its owner for care rendered to me at A Little Skin Studio, and that such coverage requires that I agree to resolve all such complaints through binding arbitration, as defined in the Physician-Patient Arbitration Agreement herein.