



## Harmony Skin Rejuvenation Consent Form

I, \_\_\_\_\_, authorize Body Fountain to perform the Harmony Skin Rejuvenation procedure and any other measures which in their opinion may be necessary.

I understand that the Harmony is a device used for skin rejuvenation and that clinical results may vary in different skin types. I understand there is a possibility of short-term effects such as reddening, blistering, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me \_\_\_\_\_ (patient's initials)

Clinical results may vary depending on individual factors, including medical history, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment.

I understand that treatment by the Harmony Skin Rejuvenation system involves a series of treatments and the fee structure has been fully explained to me \_\_\_\_\_ (patient's initials)

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. 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. \_\_\_\_\_ (patient's initials)

I understand that immediately following the laser treatment, redness, swelling, discomfort, bruising, and discoloration may develop at the treatment site. I further understand that any discoloration may last 7-14 days, and swelling should resolve within several days. Discomfort may be treated with the application of cool compresses or topical soothing agents. \_\_\_\_\_ (patient's initials)

I acknowledge that I have not been sun tanning or used self tanner for the previous FOUR weeks. I agree to stay out of the sun or to use sufficient sun block for FOUR weeks following my treatment. I agree to call the clinic if I develop any markings on my skin after treatment, and I will not pick at them. \_\_\_\_\_ (patient's initials)

If I have forgotten to tell the clinic staff of my health problems, medications, allergies, or other important information about me, I will do so now. I will inform the doctor if I am pregnant. \_\_\_\_\_ (patient's initials)

My eyes will be covered with laser/IPL -specific safety eyewear to protect them from the intense light. My eyes will be closed, and I will not attempt to remove the eye protection during treatment. \_\_\_\_\_ (patient's initials)

I confirm that I am not pregnant at this time, and that I have not taken Accutane within the last 6 months.

\_\_\_\_\_ (patient's initials)

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion. \_\_\_\_\_ (patient's initials)

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form. \_\_\_\_\_ (patient's initials)

I hereby give my permission to undergo Harmony Skin Rejuvenation Laser Treatments.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_