SKIN REJUVENATION CONSENT FORM & CLIENT INSTRUCTIONS (PRE/POST)

I _____ authorize Anti-aging Centers of Connecticut, LLC and it's designated staff to perform Skin Rejuvenation treatments on me. I have been advised of pre-post treatment procedures and possible adverse reactions which are as follows:

PRE-TREATMENT INSTRUCTIONS:

1. Avoid the sun 2-4 weeks before and after Skin Rejuvenation Treatments using photo light, lasers and radio frequency.
2. If you have had a history of perioral herpes, prophylatic antiviral therapy may be started the day before treatment and continued one week after treatment. Discontinue any irritant topical agents for 2-3 days prior to treatment. For clients treating their face, please discontinue Retin A (tretinoin) for at least 1 week, no Accutane in prior 6 months, no injectable fller for 4 weeks prior to treatment, and no Botox 1 week before and 1 week after.
3. Skin should be free of all products: makeup, creams, oils, etc. the day of treatment. All exfoliating products containing a scrub or acids ie.(p50) should be discontinued 3 days before and 1 week after.
4. If you are orally taking Fish oils, vitamin E or 325 mg of aspirin for best results you should stop 1 week before treatment.
5. A topical anesthetic can be applied one hour prior to treatment (if neccessary).all options will be discussed with me during consultation.

INTRA-TREATMENT CARE:

If skin experiences an excessive reaction, cool the treatment area immediately after treatment. Be sure to have cool packs (not frozen) or cold, wet towels.

POST-TREATMENT CARE:

1. Immediately after treatment, there should be erythema (redness) and edema (swelling) at the treatment site which may last up to 2 hours or longer. The erythema may last up to 2-3 days.. I may experience transient purpura, bruising, and may note nodule like lumps in the vessel. The bruising may last up to 3 weeks or longer, depending on the size and color of the vessel. Possible hyperpigmentation (increased brown color) or hypopigmentation (lighter color pigment) may occur within two weeks of treatment. If hyperpigmentation occurs, a bleaching cream may be prescribed to reduce the pigmentation. Contact Anti-Aging Centers of Connecticut, LLC at 203-848-1484 West Haven or 203-256-0095 Fairfield after hours 203-887-1237.

   Antibiotic ointment or some other soothing ointment or gel, or Aloe Vera gel may be used for a few days after the treatment. Improper care of the treated area may increase the chance of scarring or skin textural changes. This has been discussed with me.

   • I must avoid sun exposure on area while doing treatments and the reasons have been discussed with me.
   • Use of a 46+ sun block post treatment is recommended.
   • Avoid Scrubbing or trauma to the treated area.
   • Topical creams and medications may be resumed when erythema and skin irritation decrease.

   The application of a cold pack during the first few hours after treatment will reduce the discomfort and swelling that may be experienced but we recommend only aloe vera gel after treatment. Rarely, minor epidermal blistering may occur in which case polysporian cream may be applied. If this should happen, please contact our office immediately and our nurse will give you further instructions.
2. Makeup may be used immediately after treatment unless there is epidermal blistering. It is recommended to use ONLY NEW makeup to reduce the possibilities of infection (Folliculitis).
3. Avoid sun exposure to reduce the chance of hyper pigmentations or darker pigmentation for 2-4 weeks post treatment. Use sunscreen (SPF 46 or greater) at all time throughout the course of treatment.
4. Avoid picking or scratching of the treated skin. If you are experiencing itchy skin, apply 1% hydrocortisone cream or Elta MD enzyme gel as needed to avoid irritation.
5. Call our office with any questions or concerns you may have after the treatment.
6. There are no restrictions on bathing except to treat the skin gently. For 48 hours: No scrubbing, rubbing or harsh products; treat as if you had sunburn.
7. Exercise is not recommended for the first 24-48 hours after treatment.

Anti-Aging Centers
laser hair removal, cosmetic skin rejuvenation & esthetics

Fairfield: (203) 256-0095 | 2324 Post Road | Fairfield, CT 06824
West Haven: (203) 848-1484 | 764 Campbell Avenue, Suite F | West Haven, CT 06516
After Hours: (203) 887-1237 | www.aacofct.com

I understand that the _____(specify device) is a device used for , skin rejuvenation, acne treatment, wrinkle reduction, skin resurfacing, facial vessels, leg veins and other vascular lesion treatments, of which I am consenting to be a patient receiving _____ treatment (specify procedure).

I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre- and post-treatment instructions, and individual response to treatment. I understand that there is a possibility of short-term effects such as reddening, mild burning, temporary bruising and temporary discoloration of the skin, as well as the possibility of rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me _____ (patient's initials).
I understand that Skin rejuvenation treatments 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. I confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken. I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion. 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. I consent to the taking of photographs during the course of my therapy for the purpose of medical education. I understand that my identity will not be revealed on the photographs or corresponding text.

By signing below, I acknowledge that I have read and understand all information presented to me before signing this consent form. I hereby release Anti-Aging Centers of Connecticut, LLC, its medical staff and technicians from any liability arising out of the services associated with the above treatment.

Page 2 of 2 Client Signature: _____ Date _____

Parent signature for clients under 18 years of age: _____

Technician Signature: _____ Date _____

I have received a copy of the Consent & Client Instructions

Client Signature: _____ Date _____