ECLIPTIC MEDI-SPA

PLASMALIFT

Disclosure & Consent for Fibroblast Skin Treatment

Client Information:

Name:_____

Date:_____

Address:_____

Date of Birth:_____Phone:_____

I, _____ as a client have requested that you describe the procedure to be utilized so that I may make an informed decision whether or not to undergo the procedure. You have described the recommended procedure to be used as Fibroblast Skin Treatment, where an Electrode is held 1-2 mm from skin surface and combined with a high voltage to allow a current to overcome the resistance of air gap between tissue and electrode tip: causing superficial tissue dehydration and carbonization while releasing heat into the dermis. The carbonized epidermis insulates and minimizes further damage to the underlying dermis, creating an effective yet non-invasive treatment. I voluntarily request to have a technician on behalf of Eternal Beauty as my cosmetic technician, and such association and technical assistance as my technician may deem necessary to perform on my body the Fibroblast Skin Treatment procedure.

Please Initial:

_____I have informed the technician that I am in good health and I am not under the care of any physician.

OR

_____I am currently under the care of a physician and I am being treated for the following condition(s): _____

Physician's Name: _____Physician's Specialty: _____

Address: _____

Phone: _____

Please Initial:

_____ I am over the age of eighteen and truthfully represented to my technician that undergoing the procedure is my choice.

_____ I am not pregnant, nursing or under the influence of alcohol or recreational drugs.

_____ I am not taking blood thinners or other medications that increase the chance of bleeding.

_____ I am not taking medications or applying topical creams that thin the skin (Accutane, retinol).

_____ I do not have acne, keloid scarring, eczema or psoriasis or any skin sensitivities.

_____ I do not have diabetes, history of hemophilia/abnormal bleeding, bloodborne pathogens or any medical condition that might affect healing of the procedure area.

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_____ I do not have infection or undiagnosed rash anywhere on my body.

_____ I do not have freckles, moles, or sunburn in the procedure area.

_____ I do not have a pace-maker installed or have an underlying heart condition.

_____ I do not have any sensitivity to dyes or local anesthetics (lidocane or prilocaine).

Please Initial:

_____ I hereby authorize the technician on behalf of Eternal Beauty to take photographs of the work performed both before and after treatment, and I further authorize the use of said photographs to be used for the purpose of anonymous samples for other clients.

_____I understand that the description of the procedure is not meant to scare or alarm me. It is simply an effort to make me better informed so that I may give or withhold my consent for this procedure.

_____I understand that the down time from this procedure is about 5-7 days but can last 10 days or more. The procedure area may be red, swollen and will have brown spots that will fall off after approximately 5-7 days.

_____I have been told that there may be known and unknown hazards related to the performance of the procedure planned for me and I understand that no warranty or guarantees have been made to me as to the results.

_____I have been told that this procedure will involve pain and discomfort.

_____I understand that the treatment is semi-permanent/permanent and will result in a change to my appearance and that no representation has been made to me as to the ability to later change or remove the results.

_____Skin treatments such as laser hair removal, plastic surgery or other skin altering procedures may result in adverse changes to the procedure area.

_____I have been told that a follow up procedure may be required.

_____Other risks involved with the procedure may include, but not limited to: infections, allergic and other reaction(s) to products applied during and after the procedure and other unknown risks.

_____I accept full responsibility for any and all, present and future, medical treatment(s) and expenses I may incur in the event I need to seek treatment(s) for any known or unknown reason associated with the procedure planned for me.

_____I have been given an opportunity to ask questions about the procedures and the procedure to be used and the risks and hazards involved and I believe that I have sufficient information to give the informed consent.

_____I understand that if I have an infection, adverse reaction or allergic reaction to the procedure, I must notify Eternal Beauty, and seek medical advise from a health care practitioner.

_____I have received a copy of the Post Procedure Instructions and agree to follow them. I also agree that if I do not follow these instructions, any touch-up needed will be done at my own expense.

_____I certify this form has been fully explained to me and I have read it or it has been read to me. I fully understand its contents.

Client Signature: _____ Date: _____

Technician Name: _____ Technician Signature: _____