**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize treatment**

**(print name) by Megan Davies or whomever she may designate to perform Plasma Fibroblast Skin Tightening.**

**Possible side effects of these injections include but are not limited to:**

* **Wound infection, scarring (extremely rare)**
* **Swelling, pain**
* **Hypersensitivity reaction to numbing cream**
* **I understand I should not be treated if I have a history of Keloid scarring, severe skin conditions, open wounds, severe acne, lupus, psoriasis or vitiligo. Also I should talk to my healthcare provider if I am on blood thinning medications or have been treated with Accutane within the last year.**
* **I attest I do not have a pacemaker/defibrillator**
* **If opioid or anti-anxiety medications have been prescribed to me I agree that I will not drive for 24 hours after taking the medication and should have a driver present at the appointment.**
* **I have not used Retinol within the past 14 days**
* **I attest I have considered alternatives to this procedure and that this has been discussed with the medical provider. I also attest that the procedure has been explained to me and I understand the downtime associated with this procedure.**
* **I agree to not pick at the dots post procedure as doing so could have permanent effects.**
* **I agree to wear sunscreen of SPF 45 or higher for 2 weeks post procedure and avoid the sun as well as abide by the aftercare instructions provided to me.**
* **I understand there will be swelling at the treatment site that can be severe. For this reason I understand upper and lower eyelids are sometimes treated at separate appointments.**
* **I understand that many people achieve results with one treatment but sometimes a second treatment is necessary. I understand that a second treatment will incur an additional cost.**
* **I understand that results are not guaranteed. In the event of unsatisfactory results I agree to be seen for a free consultation and discuss the best plan of action.**
* **I agree to contact the office in the event of any side effects I may incur from treatment, unless in the event of an emergency in which case I will call 911 or go to the closest E.R.**
* **I attest that I am not pregnant or nursing.**
* **I consent to taking of photographs during the procedure for educational purposes, marketing and for observing clinical response. Please initial here if choosing to opt out of marketing pictures \_\_\_\_\_**
* **I agree that all services provided are directly charged to me and that I am personally responsible for payment at time of treatment.**

**By signing this consent form I am agreeing to be treated with the Plamere pen for Plasma Fibroblast skin tightening and have read the form in its entirety.  I also release Megan Davies, whomever she may designate and Desert Holistic Health from any responsibility associated with the side effects mentioned above.**

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(Sign name) (date)

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