Beauty Institute and Spa Inc.
361 Cornwall Rd. Suite 104, Oakville ON L6J 7Z5
Tel. 289.291.0168; Email: indulge@beautyinstituteandspa.com

Dermastamp / Dermaroller Treatment Consent Form

FOR COLLAGEN INDUCTION + SCAR REDUCTION THERAPY

Name: _____

Phone: _____

E-Mail: _____

I am requesting a Dermastamp: Collagen Induction/Scar Reduction treatment of the skin for fine wrinkles, acne scaring or skin changes associated with actinic damage or ageing, and voluntarily by consent authorize this procedure. The preferred areas to be treated are:

_____

I understand that Dermastamp Treatment utilizes fine micro-needles to puncture into the skin surface. As a consequence, the repair process releases numerous growth and healing factors that stimulate new collagen to be deposited under the skin surface. The repair process will actually extend over a twelve to sixteen week period after treatment. I also understand that I may require a series of treatments to achieve the maximum cosmetic result. The procedure and complications have been explained to me and I have had the opportunity to have my questions answered.

I have been advised that the object of the procedure I have requested is improvement in appearance, not perfection. It is possible for imperfections to persist, and that the result might not live up to my expectations or goals. I fully understand that the practice of medicine and surgery is not an exact science and that any reputable physician cannot guarantee results. I acknowledge that no written or implied verbal guarantee, warranty, or assurance has been made to me regarding the outcome of the procedure that I herein requested and authorized. I also understand the limitations of this procedure.

I understand the complications of a Dermastamp Treatment to be as follows: Please initial each line. ( )

Erythema: The skin may remain red for generally 24 hours up to four days after Dermastamp treatment. As the skin heals the erythema will resolve. Six hours after treatment mineral makeup can be used to camouflage the erythema.

_____

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I understand that a Dermastamp can be combined with the application of serums, nutritional factors, and vitamins to stimulate optimal collagen production. _____

I understand bruising may occur as a result of treatment. _____

Hyper-pigmentation: A small number of patients may experience a hyper-pigmentation of the skin surface (especially if the skin is not protected from the sun's rays). This will resolve in several weeks and may be treated with a pigment gel cream. _____

I understand in order to avoid possible postoperative hyper-pigmentation that I net to refrain from any intensive sun light exposure and/or solarium for a period of 2 weeks. I shall use a sun block with a protection factor of 15 or higher. _____

I understand in order to avoid possible postoperative infections that I net to refrain from any exercise immediately post treatment for a period of 12 hours. _____

I shall follow the prescribed post procedure skin care to avoid infection. _____

I understand that I may require additional treatments in order to achieve maximum results and that some imperfections are not amenable to a Dermastamp treatment. _____

I understand that patients with a history of herpes simplex (cold sores) may experience a flare up of the disease. If I have had herpes sores, I will inform the physician so that he can pre-treat me appropriately. _____

I understand that infection is a rare possibility. _____

I hereby give permission for photographs of the intended treatment site for diagnostic purposes and to enhance the medical record. I agree that these photographs will remain the physician's property. I further authorize to use these photographs for teaching purposes to illustrate scientific papers, books or for use in general lectures. It is specifically understood that in any such publication or use, I shall not be identifiable. _____

I agree to follow the instructions given to me by the clinic to the best of my ability before, during, and after the procedure. I understand that patient responsibility and proper performance of the postoperative care and regular return office visits are critical to the success of the treatment. I have thoroughly read and understand the postoperative instructions and reviewed them with the physician's staff. I acknowledge that I have read and filled out the patient registration and medical history form fully and correctly to the best of my knowledge, and that the information that I have supplied is correct.

_____ _____
Date: Date:

_____ _____
Patient's Signature: Clinician Signature: