SMARTXIDE DOT TREATMENT INFORMATION AND CONSENT

ONLY SIGN IF YOU FULLY AGREE AND UNDERSTAND

ABSOLUTE
COSMETIC MEDICINE

This consent form includes general descriptions of various dermatological laser treatments, including possible benefits and risks that may occur as a result of these treatments. Your doctor or nurse will describe and discuss the specific details of your procedure with you and answer your questions.

Please read the applicable sections of this consent form carefully. This form may contain words that are unfamiliar to you. Please ask your doctor or one of his staff to explain any words or information that you do not clearly understand. You may take home an unsigned copy of this consent form to think about or discuss with family or friends before making your decision.

PROCEDURE

SmartXide Fractional Treatment for Age-Related Skin Changes, Pigmentation and Scarring.

Ablative laser treatment is a technique for eliminating blemished areas from the skin and improving lines and irregularities that result from the aging process and sun damage. The SmartXide DOT fractional ablative laser is a system designed to penetrate into the lower layers of the skin in small areas, leaving normal healthy skin in between, allowing a rapid recovery. A local or topical application of anesthetic may be applied prior to treatment to reduce discomfort caused by the laser. Photographs of the treatment area may be taken for your medical chart and future comparison. Multiple treatments are usually necessary to achieve complete satisfaction.

Benefits of this treatment include the possible reduction or elimination of unsightly pigmented lesion-like solar spots or uneven skin colour. Lines and wrinkles may be improved and unevenness due to acne scarring improved.

Possible risks or discomforts (side effects) may include pain, burning, blister formation, stinging sensation, infection, pigmentary changes including a decrease or increase in skin colour at the site of treatment, scar formation, laser-induced "cold-sore-like" blistering, skin eruptions known as "herpetic" skin eruptions at the site of treatment and poor cosmetic outcomes.

In order to ensure a positive outcome with laser treatment, reducing any risk of possible side effects, the patient must strictly follow the pre- and post-operative protocols.

GENERAL RISKS

Eye injury due to use of the laser is a risk to the patient and to the physician. The risks are almost completely eliminated with the correct use of proper eyewear.

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- This policy, information, initial assessment and the consent form includes general descriptions of various dermatological laser treatments, including possible benefits and risks that may occur as a result of these treatments.
- Please read the applicable sections of this consent form carefully. This form may contain words that are unfamiliar to you. In case of invalid clients, an authorised persons' signature will be required, or the clinic manager may choose not proceed with any treatment.
- Ask your laser nurse or practitioner, or one of the clinic staff, to explain any words or information that you do not clearly understand.
- You may take home an unsigned copy of this consent form to think about or discuss with family or friends before making your decision.

My signature below constitutes my practitioner, that

_____ _____

PRINT NAME DATE OF BIRTH

I am a competent, consenting adult of at least 18 years of age (or my parent or legal guardian is giving consent on my behalf), and further, that I:

- have received all the information I desire concerning my procedure. Y/N
- have read and understand the information provided in this form. Y/N
- have had my procedure adequately explained to me by the practitioner. Y/N
- consent to photographs of the treatment area. Y/N
- understand all pre- and post-treatment recommendations. Y/N
- assume any risks of complications or injury from known or unknown causes associated with, relating to, or otherwise arising from this procedure. Y/N
- have the right to consent to or refuse any proposed procedure at any time prior to treatment. Y/N
- will notify the clinic if my medical history changes. Y/N
- agree / do not agree for the clinic to inform my GP of this treatment.
- nominate _____ to give consent on my behalf. Y/N
- consent to, and authorise: _____

(PRINT OPERATOR / NURSE / CLINICIAN'S NAME)

to perform the laser treatment for: _____

(PRINT NAME OF LASER PROCEDURE TO BE CARRIED OUT)

_____ _____

Signature (Patient, or signature of parent/guardian) **Date**

Printed name of signatory: _____

If signed by other person, indicate relationship: _____

I cannot dispute what I have read, agreed to and signed above . If I do then I agree to pay all costs incurred by ACM if I breach this agreement.

I agree to follow the ACM social media policy and pay all costs incurred by ACM if I breach this policy.

I understand that photographs are for clinical use only. I am responsible for taking my own photographs for my records. (please initial) _____