# Derma V Treatment Consent Form

This form is designed to provide you with the information you need to make an informed decision on whether or not to have a DermaV Treatment procedure performed. If you have any questions or do not understand any part of this consent, please do not hesitate to ask us.

I **[\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]** hereby authorize **[\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]** to perform a treatment on me. I understand that the procedure is purely elective and I have chosen to receive treatment for:

□ Treatment of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Area:

□ Treatment of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Area:

□ Treatment of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Area:

I understand the nature of my condition, the nature of the procedure, the alternative treatments available, and the benefits to be expected compared with alternative approaches. I understand that optimal results may be achieved with a series of treatments. A treatment plan has been fully explained to me.

Just as there are benefits to the procedure proposed, I understand that this procedure also involves risks. I understand that serious complications are rare but possible. Potential side effects include Edema, Erythema, Bruising (Ecchymosis), Purpura, Crusting, Burning sensation, Hyperpigmentation, Scarring, Blistering, Inflammation, Ulceration, Pitting, Pigmentary changes, Oozing, and Blanching.

I consent to photographs being taken to evaluate treatment effectiveness, for research, medical education and training. No photographs revealing my identity will be used without my written consent. By signing below, I am providing my consent that my “unidentifable” photos may be used for the above stated purposes.

“Before and After Instructions” have been discussed with me. The procedure, as well as potential benefits and risks, have all been explained to my satisfaction. I have had all my questions answered. I freely consent to the proposed treatment. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian/person having legal custody will also be required before treatment.

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| Patient Signature |  | Print Patient Name |  | Date |
|  |  |  |  |  |
| Treatment Provider Signature |  | Print Treatment Provider Name |  | Date |