



Micro Fractional Skin Resurfacing Consent Form

I understand that eCO2 Ablative Micro Fractional Skin Resurfacing is intended for treatment of wrinkles, acne scars, skin tone and skin texture and that treatment is commonly performed over facial and non-facial areas.

The procedure involves creation of micro ablative columns or MAC (columns of laser light that targets only a small percentage of skin) using a CO2 laser with a computerized scanning hand piece. The treatment is termed “ablative” because it creates microscopic wounds to the surface of the area. This enables the skin to undergo a remodeling and/or healing process with very little likelihood of significant problems such as scarring or permanent discoloration.

I understand that complications including scarring or permanent discoloration are possible. Pinpoint bleeding may also occur. Short-term side effects such as reddening, swelling, mild burning sensation or temporary discoloration of the skin are not uncommon. Milia formation, acne flare-up or herpes simplex virus breakouts in the mouth region are also possible.

Patients should expect improvements in skin texture, tone, pigment, reduction of wrinkles and improvement of scar. Depending on the depth of the treatment and the spacing of MACs, the downtime for recovery can be minimal to as short as a weekend. Downtime may be longer for deeper treatments or for certain combination treatments.

I understand that treatment is contraindicated in patients currently taking anti-coagulants, with an active skin infection, isotretinoin use in the past year (i.e. Accutane), compromised immune system, history of keloids, pregnancy and with skin cancer in the treatment area.

With this in mind, I am choosing to undergo

Full-Face Facial Region Neck Upper Chest Hands Other

I have read and understand this form and my questions have been addressed and answered to my satisfaction. I have read pre-treatment considerations and post-treatment instructions and I will follow the recommendations outlined to protect my skin.

Patient's Name :

Signature :

Date :

Witness Name :

Signature :