BH Skin DERMATOLOGY

INFINI 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 an INFINI RF 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 **BHSkin Dermatology (Don Mehrabi MD APMC)** to perform an RF treatment on me. I understand that the procedure is purely elective and I have chosen to receive treatment for:

- ❑ Treatment of wrinkles _____(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 are achieved only with a series of treatments and that I will not see optimal results after one treatment. The need to complete 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. Common side effects include temporary pinpoint bleeding. Redness, swelling and mild "sunburn" like effects that may last a few hours to 3-4 days or longer.

Microdot spots or slightly raised bumps, or pigment changes (light or dark spots on the skin) lasting 1-6 months or longer may occur. Other potential risks include acne or Herpes Simplex breakout, itching, pain, bruising, or infection. There is a rare possibility of burn, blistering, erosion or a scar at the treatment site may develop.

I consent to photographs being taken to evaluate treatment effectiveness, for medical education and training. No photographs revealing my identity will be used without my written consent.

"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.

_____	_____	_____
Patient Signature	Print Patient Name	Date
_____	_____	_____
Physician Signature	Print Phycisian Name	Date