Dermapen Cryo
TREATMENT CONSENT FORM

PATIENT DETAILS

FULL NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

PHONE NO. (M): _____ (H): _____

EMAIL ADDRESS: _____

TO THE PATIENT:

It is important that you are informed about your skin condition and proposed treatment including the potential benefits and risks involved. This disclosure is not meant to scare or alarm you; it is simply an effort to better inform you, so that you may give or withhold your consent to the treatment.

I , _____ , have requested to be treated with Dermapen Cryo™ to remove my benign skin lesion (ie. skin tag, skin wart, brown spots). Any concerns that a treated skin lesion is anything other than benign has been cleared by a medical practitioner prior to this treatment.

RISKS AND SIDE EFFECTS:

Dermapen Cryo™ Therapy is relatively low-risk and side effects and complications are usually minimal. Even so, side effects *may* occur as a result of this treatment. These include:

• Pigment changes. Both hypo-pigmentation (lightening of the skin) and hyper-pigmentation (darkening of the skin) are possible. Both generally only last a few months, but can be longer lasting.

• Nerve damage. Though rare, damage to nerves is possible, particularly in areas where nerve endings lie closer to the surface of the skin, such as the fingers, the wrist, and the area behind the ear.

• Shards of frozen ice. The innovation of Dermapen Cryo™ is the direct application of nitrous oxide under high pressure (55 bar). This high pressure jet may cause minor shards of frozen ice in the air blown away in a circle of approximately 30cm. These shards will thaw the moment they eventually touch healthy skin.

• Lesions on sites with coarse terminal hair. Hair follicles are easily damaged by cryosurgery and permanent alopecia is not uncommon.

I have been advised of the risks involved in such treatment, the expected benefits of such treatment, and alternative treatments, including no treatment at all.
I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and that I have had sufficient opportunity for discussion and to ask questions. I consent to this procedure today and for all subsequent treatments.

Patient's Signature: ..... Date: .....
Operator's Signature: ..... Date: .....

Dermapen Cryo
TREATMENT MODEL CONSENT

Photography / Video Release

TREATMENT MODEL CONSENT FORM

As part of your treatment, we will be photographing the treatment area of your body/face (and in some cases, filming the treatment process). This will allow us to visually monitor your individual progress and see the results of your treatment over time. We would appreciate your willingness to share your outcomes and results with others, for both training and marketing purposes within the beauty, cosmetic and aesthetic industry. In all cases we will do everything we can to keep your identity anonymous.

With this form I, (participant's name) ..... , give my full consent for all photographs/footage captured before, during and after my treatment by (practitioner's name) ..... to remain the property of the clinic and the aesthetic equipment supplier DermapenWorld.

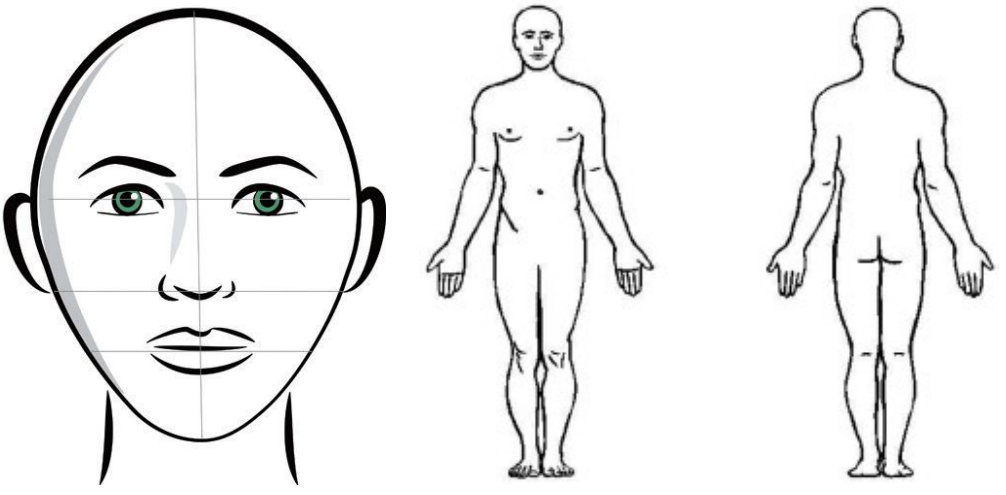
With this consent, I give permission for the images/footage (if they are to be selected) to be used in the following and similar materials (please tick one or both preferences):

Marketing and advertising for either the clinic or DermapenWorld, to be used on company websites, in-clinic waiting room materials or other such industry media channels. Examples are product/treatment brochures, clinic advertising material and information made available to other clients interested in the treatment.

In training purposes, educational material for the clinics, DermapenWorld and internal use only. Such as user product manuals, educational charts and industry communications.

Patient's Signature: ..... Date: .....

Area(s) Treated:



Notes: .....
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