PiXel8 Radio Frequency Micro Needling System Skin Tightening Consent Form

SECTION 1: AUTHORIZATION AND DESCRIPTION OF TREATMENT

I, _____ , authorize and consent to the treatment for skin tightening with the PiXel8 Radio Frequency Micro Needling System. I understand this is an elective cosmetic procedure and fully consent to the Pixel8 Radiofrequency Micro needling treatment.

The procedure, including the benefits, risks, potential side effects, and alternative treatment options, has been fully explained to me.

SECTION 2: DISCLOSURE OF RISKS AND COMPLICATIONS

I accept the possible complications of the procedure. I understand that risks include, but are not limited to, the following potential side effects, which may be temporary or, in rare cases, permanent:

- Temporary discomfort, pain, redness (erythema), swelling (edema), and bruising at the treatment site.
- Thermal injury, burns, or blistering.
- Infection, which may require medical intervention.
- Changes in skin pigmentation (hyperpigmentation or hypopigmentation).
- Scarring (Keloid or hypertrophic).
- Potential reactivation of existing cold sores or herpes simplex outbreaks.

SECTION 3: ACKNOWLEDGEMENT OF RESULTS AND FINANCIAL RESPONSIBILITY

I understand that no guarantees are implied as to the outcome of the procedure.

- I understand that Luxe Medical does not guarantee a specific result, percentage of improvement, or a permanent change.
- I understand that multiple treatments may be necessary to achieve optimal results.
- I confirm that I am financially responsible for the full cost of this procedure regardless of the outcome.

SECTION 4: INDEMNIFICATION AND WAIVER OF LIABILITY

I hereby indemnify and hold harmless Luxe Medical and their employees, the treating technician, and the staff at the office of _____ from all liability, damages, cost, and expenses arising from or out of the use of the Pixel8-RF, provided that the procedure was performed with reasonable care and standard clinical protocols.

SECTION 5: MEDICAL HISTORY AND CARE INSTRUCTIONS

I will notify my service provider if there are any changes to my medical history including new medications or supplements.

- I certify that all medical history and information I have provided to Luxe Medical is complete and accurate. _____ (initials)
- Pixel8-RF pre- and post-treatment instructions have been reviewed and provided to me. _____ (initials)
- I understand that not adhering to the care instructions provided may increase my risk of complications. _____ (initials)
- I understand that I should only apply products recommended by my clinician post treatment. _____ (initials)
- I will notify my service provider if I have a known history of cold sores, fever blisters or herpetic outbreaks. _____ (initials)

SECTION 6: CERTIFICATIONS

I certify that I do not have any electronic implants (pacemaker, insulin pump, etc.). _____ (initials)

I certify that I do not have any metal implants in the area being treated. _____ (initials)

I certify that I do not have a known gold allergy. _____ (initials)

I certify that I am not pregnant or breastfeeding. _____ (initials)

I agree to have before and after photographs taken of the treatment area. _____ (initials)

SECTION 7: CLIENT ACKNOWLEDGEMENT AND SIGNATURES

I have read and understand all information presented to me. I have been given an opportunity to ask questions before signing this consent.

In case of complications outside of regular business hours, I understand I should contact: (Provide Clinic Emergency/After-Hours Number Here) or seek emergency medical attention if necessary.

Patient: _____ Date: _____

Witness: _____ Date: _____