3730 7th Terr., Suite 302A, Vero Beach, FL 32960| (772) 492-6973

I hereby authorize __________________ to perform the Skinwave aqua delivery treatment on me. I understand and acknowledge that my skin, though unlikely, may experience temporary redness, irritation, and/or tightness. When present, this usually resolves within 48 hours.

The procedure may result in the following adverse experiences or risks:

- DISCOMFORT/PAIN- Some discomfort and/or pain may be experienced during treatment, but is unlikely.
- REDNESS/SWELLING/BRUISING- Redness (erythema) or swelling (edema) of the treated area is common and may occur. There may also be some bruising.
- HYPOPIGMENTATION/HYPERPIGMENTATION: (Changes in skin color): - During the healing process, there is a slight possibility that the treated area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- WOUNDS – Treatment can result in burning, blistering, or bleeding of the treated area(s), but is unlikely.
- SUN EXPOSURE/TANNING BEDS/ ARTIFICIAL TANNING – Should be avoided because it may increase risk of side effects and adverse events.
- INFECTION – Infection is a possibility whenever the skin surface is disrupted, although proper wound care should prevent this. If signs of infection develop, such as pain, heat, or surrounding redness, please call our office at (772)492-6973.
- SCARRING – Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.

I acknowledge that the following points have been discussed with me:

Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me
Alternative treatments and my options
Reasonably anticipated health consequences if the procedure is not performed
Possible complications/risks involved with the proposed procedure and subsequent period

I understand all below contraindications for this procedure:

- Malignant tumor
- Children
- Pregnant or nursing women
- Herpes
- Epilepsy, Infection and Rash
- Inflammatory Response
- Hemorrhagic disease (Hemophilia)
- Cardiovascular Disease
- Nephritis
- Pacemaker
- Insulated Metal Stand
- Dysarteriotomy
- Diabetes
- Dermatopathy
- Anticoagulants
- Autoimmune Disease
- Facial Paralysis
- Lupus/Achromoderma
- High Fever
- Menstruation
- Filler
- Implant (Dentistry, Plastic Surgery. Orthopedics)
- Bleeding cuts
- Chronic dermatopathy impacting topical or whole body
- Keloid Skin
- Weak to electric shock therapy
- Febrile patient (38°C)
- Other extraordinary disease

For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become anytime during the course of this treatment.

Photographic documentation will be taken. I hereby do __ do not ___ authorize the use of my photographs for teaching and/or advertising purposes.

Acknowledgement

By my Signature below, I acknowledge that I have read and fully understand the contents of this informed consent for this treatment, and that I have had all my questions answered to my satisfaction by my health care team.

____

Signature- Patient or Guardian **Print Name/Relationship** **Date**

____

Signature- Witness **Print Name/Title** **Date**