Consent and Release Form For Dermapen Treatment

Laser Lounge Med Spa, LLC
2002 Williams Dr. Georgetown, TX 78628 - 512.863.2118

Patient Name (Print): _____

Address: _____

Email: _____ Phone: _____

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 program.

I _____ of (address as above) have requested a Dermapen Treatment to attempt to improve my facial expression lines and/or skin surface.

The practice of medicine is not an exact science and no guarantees can be made or have been made concerning expected results. I understand that several appointments may be necessary to complete the treatment.

Risks and side effects:

Side effects and complications are usually minimal. Occasionally you may experience erythema, bleeding, temporary scarring, dryness and/or discomfort. 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 to indemnify, hold harmless, and release from any and all liability the service provider as well as any officers, directors, assigns, insurers, affiliates or employees of the provider for any condition, result, or negligence known or unknown that may arise as a consequence of any treatment that I receive.

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: _____

PLEASE TAKE THE TIME TO READ THIS CAREFULLY AND TO UNDERSTAND ANY ACCOMPANYING INFORMATION

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 progress). 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 beauty, cosmetic and aesthetic industry. In all cases we will do everything we can to keep your identity anonymous.

With this form I, (insert participants name) _____ give my full consent for all photographs/footage captured before, during and after my treatment by, (insert clinic/practice name) _____ to remain the property of the clinic and the aesthetic equipment supplier Dermapen.

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 check one or both preferences)

□ Marketing and advertising for either the clinic or Dermapen 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, educated material for the clinics, Dermapen and internal use only. Such as user product manuals, educational charts and industry communications.

Patient Signature: _____ Date:_____

PLEASE TAKE THE TIME TO READ THIS CAREFULLY AND TO UNDERSTAND AND ACCOMPANYING INFORMATION

Before and after photos will be taken to monitor your progress. You may choose to opt-out photos being used for marketing/educational purposes by signing below.

Patient Signature: _____ Date:_____

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