ELECTIVE AESTHETIC PROCEDURE CONSENT FORM

AVISSA SKIN

I, the undersigned, do hereby request, consent to undergo, and authorize Avissa Skin, and its employees, independent contractors, associates, agents, and representatives (collectively and hereby known as “Practice”) to perform, implement, and/or assist in the following elective aesthetic procedure. I understand that elective aesthetic procedures are not medically necessary or required. I also understand that the Practice only implements elective aesthetic procedures and does not diagnose, treat, or cure medical conditions.

Desired Elective Aesthetic Procedure: **LASER HAIR REMOVAL** **CLARITY II by LUTRONIC** _____ Initials	I have received a copy of both the procedure information sheet and the pre / post-care instructions for this elective aesthetic procedure. My initials indicate that I have carefully read and fully understand these documents. _____ Initials

To the best of my knowledge, I have provided a full and accurate account of my medical history; including all known allergies, pre-existing conditions or complications, prescription medications, supplements, and other products that I am currently ingesting or using topically. **I am not pregnant or lactating.**

Although it is impossible to list every potential risk or complication for any aesthetic procedure, the nature of this elective aesthetic procedure and its benefits, possible risks, side effects, complications, and available alternative procedures have been fully explained to me. I have been given ample opportunity to ask questions, all of which have been answered satisfactorily. I realize that, as in all aesthetic procedures, complications or delays in recovery may occur which could lead to the need for additional procedures, and could result in a delay to one’s normal daily activities and thus economic loss. **I understand that compliance with the pre / post-care instructions as well as recommended follow-up visits are crucial in minimizing the risk of any complications.** I understand that occasionally photographs and videos will be taken before, during, and after the procedure by the Practice for in-office clinical documentation and progress monitoring.

I am personally responsible for the full payment of professional procedures performed. I understand and accept that all fees are paid for the performance of aesthetic procedures only, not guaranteed results. I acknowledge that although a good outcome is expected and a reasonable effort has been made to achieve realistic expectations, there cannot be any guarantee, expressed or implied, as to the results that may be obtained. I recognize that I may require further procedures of the same nature to obtain the desired results at an additional cost.

I freely accept all possible risks, side effects, and complications that may result from this elective aesthetic procedure and I release the Practice from any liability directly or indirectly related to this procedure. This consent is voluntarily executed and shall be binding on my spouse, relatives, legal representatives, heirs, administrators, successors, and assignees. **This consent is valid for all future sessions of the above elective aesthetic procedure.** I agree to inform the Practice if there are any changes in my medical conditions, medications, or if I become pregnant. I am 18 years of age or older and I confirm that I read and write in English.

Print Patient Full Name	Patient Signature	Date

Reviewed By _____ Initials