INFORMED CONSENT – TITAN PROCEDURE

TO THE PATIENT:

Being fully informed about your condition and treatment will help you make the decision whether or not to undergo the Titan procedure. This disclosure is not meant to alarm you; it is simply an effort to better inform you so that you may give or withhold your consent for this treatment.

I hereby authorize The Medical Director(s) or any delegated associates to treat me with the Titan device. I understand that this procedure works by creating a thermal response in the dermis that induces collagen contraction and stimulates new collagen. There is little or no downtime associated with this treatment. It is possible the result will be minimal or not help at all.

_____

(Patient's Name)

I am aware of the following possible experiences/risks:

_____ DISCOMFORT – Some discomfort may be experienced during treatment.

_____ REDNESS/SWELLING/BRUISING – Short term redness (erythema) or swelling (edema) of the treated area is common and may occur. There also may be some bruising.

_____ PIGMENT CHANGES (Skin Color) – During the healing process, there is a possibility that the treated area can 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 areas. If any of these occur, please call our office.

_____ 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 Alamo Hills Advanced Aesthetics & Laser Center.

_____ SCARRING – Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the changes of scarring, it is IMPORTANT that you follow all post-treatment instructions carefully.

_____ EYE EXPOSURE – Protective eyewear (shields) will be provided. It is important to keep these shields on at all times during the treatment in order to protect your eyes from injury.

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The following points have been discussed with me:

- Potential benefits of the proposed procedure
- Probability of success
- Reasonably anticipated consequences if the procedure is not performed
- Most likely possible complications/risks involved with the proposed procedure and subsequent healing period
- Post-treatment instructions

For women of childbearing age: By signing below I indicate that I am not pregnant. Futhermore, I agree to keep The Medical Director(s) and staff informed should I become pregnant during the course of treatment.

_____I consent and authorize a trained physician, registered nurse, physician assistant, or nurse practitioner of Alamo Hills Advanced Aesthetics & Laser Center to perform Titan treatments.

Photographic documentation will be taken. I hereby do___do not___authorize the use of my photographs for teaching purposes.

Patient Consent

I certify that I have read and understand this treatment agreement and that all the blanks were filled prior to my signature.

_____ _____

Patient Signature/Date **Witness Signature/Date**

_____ _____

Print Name **Print Witness Name**

Physician or Clinician Certification

I certify that I have explained the nature, purpose, benefits, risks, complication and alternatives to the proposed procedure to the patient. I have answered all questions fully and I believe that the patient fully understands what I have explained.

_____ _____

Clinician Signature **Date**

Alamo Hills Advanced Aesthetics & Laser Center