AEGEAN
MEDICAL

Dermapen & PRP Facial Consent

Name: _____ DOB: _____ Date: _____

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 simply an effort to better inform you so that you may give or withhold your consent to the treatment program.

I have requested a Dermapen Treatment to attempt to improve my facial expression lines and or skin surface. ☐ **Without PRP** ☐ **With PRP**

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

Risks and side effects:

Side effects and complications are usually minimal. Occasionally you may experience redness, swelling, tightness, bleeding, temporary scarring, dryness and or discomfort.

My signature certifies that I have discussed the above materials with Angelo A. Tellis M.D., and I understand the goals, limitations, and possible complications of Dermapen micro needling, and I wish to proceed with the procedure.

I hereby authorize and give my consent to Angelo A. Tellis M.D. and/or Aegean Medical staff, to perform upon me Dermapen micro needling ☐ **Without PRP** ☐ **With PRP**, and whatever procedures, treatments or technical procedures which may be deemed necessary or advisable in the treatment of my case. I also give my permission to have such topical anesthetics applied as are deemed necessary or advisable.

I give permission to Aegean Medical staff to take before and after photographs. These photos will only be used for myself and Aegean Medical staff to show the changes from my procedure.

This particular procedure, which I am about to undergo has been explained me in detail and I understand in general what is to be done, that there are calculated risks, and that Angelo A. Tellis M.D. and Aegean Medical staff have not made any guarantee whatsoever.

_____ _____
Patient Signature Date

_____ _____
Witness Signature Date

_____
Angelo A. Tellis MD

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MEDICAL

PHOTO/VIDEO RELEASE CONSENT

I, _____ , give permission to Aegean Medical staff to take and use photographs, audio, and video recordings of me without compensation, including appropriate portions of my body, for medical, scientific, promotional, or educational purposes provided **my identity is not revealed** in the process.

_____ (initial) I give permission to be on Snapchat

I further agree to hold Angelo A. Tellis M.D. and Aegean Medical staff free and harmless from all claims arising from the use of said photographs, audio, and video recordings when used within the scope described above.

_____	_____	_____
Patient Signature	DOB	Date

_____	_____
Witness Signature	Date

AMERICAN ACADEMY OF COSMETIC SURGERY
Educating for Patient Safety