AEGEAN
MEDICAL

Plasma Skin Resurfacing Procedure Consent Form

Name: _____ DOB: _____ Date: _____

I have had the opportunity to ask questions about the procedure, its limitations and possible complications. I express that I clearly understand and accept the following; myself or through my legal guardian.

--Plasma skin resurfacing is a process by which plasma energy is applied to the skin in an attempt to change the appearance of lines, wrinkles, skin blemishes, scars and certain other localized skin conditions. Plasma skin resurfacing will neither stop the aging process nor totally eliminate wrinkles. The final result of treatment may not be apparent for several months. Future treatment may be necessary, depending upon the success of this initial treatment.

--Treated areas will have a reddish appearance that will persist for several weeks or longer. At the junction between treated and untreated areas, while the doctor will blend the two areas, a different skin color or blotching may occur. Although rare, the texture of the skin may be permanently altered. Deep areas of skin wrinkling may be not be fully corrected and require additional resurfacing. In addition, areas of deep skin scarring (usually from acne) may require additional resurfacing treatment. The risk of infection is rare, but should it occur, topical and /or systemic antibiotic therapy may be necessary.

--Plasma skin resurfacing usually causes some discomfort and swelling. Oozing typically occurs and the area may become covered with a crust which will normally separate within 7 to 10 days. It will be necessary to clean the resurfaced area 4-5 times daily and to keep the area covered with prescribed medications or ointments. Failure to do so may have negative effects on healing and the final result of procedure.

--Hyperpigmentation (the color of the treated areas becomes darker than the surrounding skin) is the most common side effect. Certain medications may be prescribed or recommended to help these pigment complications usually fade in 6-12 months; however they may be permanent. **Please inform your doctor if you have used Accutane®, Tegison®, or any other medications prescribed by your physician or dermatologist during the past year. It is also very important to advise your doctor if you have ever had cold sores or other blister lesions on your face.**

--Small whitish bumps, called milia, may occur. They may require local treatment or medication to help them clear.

--Scarring is a possible complication. The scars may be hypertrophic scars that are thickened scars, and/or keloid scars that are abnormal, raised scars that may extend beyond the limits of the original scar.

--Ectropion, an outward turning of the eyelids, may occur with plasma treatment. It is usually temporary, but may require further treatment, including additional procedure. Plasma energy can cause eye injury, including blindness. It is important to keep your eyes closed during plasm procedure.

Name: _____ DOB: _____ Date: _____

--This is an elective, cosmetic procedure and I understand that results may vary due to individual patient differences. It is possible that my skin condition may worsen and that selective re-treatment may be required. I realize there can be no guarantee that the proposed treatment will be curative (healing) or meet all aesthetic (sense of beauty) expectations.

--I have provided a full and truthful health and social history, including drug, alcohol and tobacco use. I understand that withholding information may delay healing and jeopardize the planned goals of procedure. I agree to cooperate fully with my doctor's recommendations while under treatment, realizing that lack of cooperation can increase risks and complications.

--If any unforeseen condition should arise during procedure that may call for additional or different treatment from that planned, I authorize my doctor to use professional judgment to provide appropriate care.

--I agree to avoid direct sunlight for two (2) months after treatment and to use sun block of at least SPF 30 for 12 months thereafter. I also agree to decrease alcohol and tobacco use as much as possible, recognizing their negative effect on healing.

_____ (initial) I have been informed of the pre and post-procedure instructions and given a copy.

FOR FEMALE PATIENTS

--I have informed my doctor about my use of birth control pills. I have been advised that antibiotics and other medications may reduce the preventive effect of birth control pills and may result in conception and pregnancy. I agree to consult with my physician to initiate alternative forms of birth control during the period of my treatment, and to continue those methods until advised by my physician that I can return solely to the use of birth control pills.
--I understand that I may not be a candidate for this procedure if I am pregnant, might be pregnant, or am nursing a child. I agree to notify Dr. Tellis if I am or become pregnant.

My signature certifies that I have discussed the above materials with Angelo A Tellis M.D. and/or Aegean Medical staff, and I understand the goals, limitations, and possible complications of plasma skin resurfacing, and I wish to proceed with the procedure.

I hereby authorize and give my consent to Angelo A. Tellis M.D., to perform upon me plasma skin resurfacing, and treatments or technical procedures which may be deemed necessary during the procedure. I also give my permission to have such anesthetics administered 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	DOB	Date
_____	_____	_____
Witness Signature	Date	Angelo A. Tellis MD

Aegean Medical at Crystal Coast Pain Management & Azura Skin Care Center
www.aegeanmedical.com
252-617-7234

AEGEAN
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