Shining Way Esthetics

Patient Consent Form

eMatrix Sublative Rejuvenation

I duly authorize Dr. Adherbal "Herb" De Souza, DNP to perform eMatrix Sublative Rejuvenation treatment for the purpose of skin rejuvenation.

I understand that the eMatrix is a device used for dermatologic procedures requiring ablation of soft tissue and skin resurfacing, of which I am consenting to be a patient receiving treatment.

I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre- and post-treatment instructions, and individual response to treatment.

I understand that there is a possibility of short-term effects such as reddening, swelling, scab formation, temporary discoloration of the skin, as well as the possibility of rare side effects such as burn, scarring and permanent discoloration. These effects have been fully explained to me _____ (patient initials).

I understand that treatment with the eMatrix involves a series of treatments and the fee structure has been fully explained to me. I understand that this procedure is considered cosmetic and is not reimbursable by government or private health care insurers. Payment in full is required at the time of service and is non-refundable. I also understand that the cost of additional treatments, including enhancements, in order to help me achieve my desired goals, will be my financial responsibility. _____ (patient initials).

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken, as well as my past and planned exposure to sun, sun-bed, and tanning creams.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Patient Signature: _____ Date: _____

Printed Name: _____

Practitioner Signature: _____ Date: _____

Printed Name: _____