Patient Name: _____ **Date:** _____

I _____ have requested an InnoPen Treatment, a non-surgical and minimally ablative treatment, in an attempt to treat my skin condition(s).

Risks/Side Effects:

Side effects and complications are usually minimal. Following the procedure, the skin will be red and/or flushed in appearance similar to moderate sunburn. You may experience erythema, bleeding, skin tightness, mild sensitivity or allergic reactions. This will diminish after a few hours following the treatment and within 24 ~ 48 hours the skin should be healed.

Contraindications:

Active Cold Sore (Herpes Simplex Virus) and Acne, Keloid Scars or Raised Scarring, History of Eczema, Psoriasis or other chronic conditions, Presence of Raised Moles, Warts or Raised Lesions on Treatment Area, New Scar Tissue/ Wounds. Absolute Contraindications include: Scleroderma, Active bacterial or fungal infection, Women who are Pregnant or Nursing.

I understand that results will vary between individuals. I also understand that I may require a series of sessions to obtain my desired outcome following my first treatment.

I confirm that I have consulted with my doctor/aesthetician and that I have informed the clinic of all medical details relevant to the treatment.

The procedure and possible risks/side effects have been explained to me and any questions have been answered satisfactorily.

ACKNOWLEDGEMENT

BY SIGNING BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THE PATIENT FORM FOR THIS TREATMENT AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.

_____ _____

Signature **Date**