Informed Consent for Hyaluronidase Injections

I _____(Patient Name) hereby authorize _____ (Medical Provider Name) and/or such assistants as may be selected to perform the hyaluronidase injections. The medical provider obtained my medical history and found me eligible for treatment.

Indication: Hyaluronidase is a protein enzyme used to dissolve dermal fillers, such as Juvederm, Restylane, Belotero, Voluma and others. The application of hyaluronidase to dissolve dermal filler is considered “off label” by the FDA. There “ on label” FDA approved uses for this agent such as adjuvant in fluid administration for achieving hydration. In terms of its cosmetic application, hyaluronidase may be indicated if previous hyaluronic acid injections used to treat wrinkles have produced an unfavorable result such as filler migration beyond the intended area or in the rare event of a vascular occlusion. It can be injected to remove just uneven bumps or lumps, or it can be injected to reverse the effects of the entire procedure.

If the first injection does not produce the desired results, the injection can be repeated to achieve more complete resolution. Most medical providers recommend a week between subsequent injections. The procedure and recovery are virtually the same as they were for the original cosmetic filler injection: No down time. There may be temporary effects such as minor tenderness, swelling, or redness at the injection site; however, any residual discomfort is expected to be minor. Once injected with hyaluronidase, the breaking down or hydrolysis of the filler tissue starts immediately.

Important Safety Information: Hypersensitivity to hyaluronidase or any other ingredient in the formulation is a contraindication to the use of this product. The most frequently reported adverse reactions have been local injection site reactions, such as erythema, bruising and pain. The use of hyaluronidase can result in dissolution of all of the dermal filler.

Consent to Treatment: I understand that there are potential risks to this treatment and that there are alternatives to this treatment. I also understand that this consent is valid for future treatments unless the policies of the office or the known risks for the product change. By signing this form, I acknowledge guarantees as to the final results cannot be made.

Initials: _____ I release the device manufacturer, medical provider(s) and staff of Valley Health Clinic LLC and Revive Aesthetics LLC from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products.

Initials: _____ I authorize before, during and after the procedure(s) the taking of photographs to be part of my patient profile that may be used for educational, promotion or advertising purposes without disclosing my identity. I also release Valley Health Clinic LLC and its associated staff including Revive Aesthetics LLC from any liability in connection with the use of such photographs and/or videos. My name will not be used to identify these photographs without my written approval.

NOTE: THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.

_____	_____	_____
Patient Name Printed	Patient Name Signed	Date
_____	_____	_____
Medical Provider Name Printed	Medical Provider Name Signed	Date

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Med Spa Services Supervised by Medical Director Dr. Abdullah Farooque MD

Plasma Pen IQ Consent Form

I _____(Patient Name) hereby authorize _____ (Medical Provider Name) and/or such assistants as may be selected to perform the PLASMA IQ procedure. The medical provider obtained my medical history and found me eligible for treatment.

Indication: The device called Plasma IQ™ is used in the removal and destruction of skin lesions and coagulation of tissue. PLASMA IQ is a minimally invasive, ablative procedure that will be performed using FDA 510k-cleared equipment and best practice safety and hygiene techniques to rejuvenate and tighten skin and reduce the signs of aging.

How it works: PLASMA IQ treatment harnesses the power of plasma energy to create small thermal wounds at the skin surface that extend deep enough (into the upper dermis) to rejuvenate and tighten skin and reduce the signs of aging. Fibroblasts, collagen, and elastin fibers are located in the dermal layer.

Providers cannot guarantee a measured tightening result due to individual skin condition at the time of treatment, including degraded collagen content and reduced skin elasticity as well as the individual healing process, your age, health and lifestyle. Achieving best results may require more than one treatment. After initial healing, a subsequent treatment may be performed, if necessary, 8 to 12 weeks later.

Procedure description: PLASMA IQ treatment involves the use of a local anesthetic, either topical or injected, for pain control. Immediately after treatment, brown dots (carbon crusts) will be visible for **approximately 5 to 7** days following the procedure. In rare cases, these brown dots may desquamate (flake off) and be replaced with pink markings while the skin is regenerating. This may last for up to 8 weeks and will typically resolve naturally as the skin heals below the surface. Minor swelling of the treatment areas and surrounding skin may be present for a few days after treatment and bruising may occur from the local anesthetic injections. The skin in the treatment area(s) may be pink for several weeks but patients with lighter skin complexions may have redness that lasts for several months before finally fading.

CONTRAINDICATIONS

- Birthmarks/Port-wine Stains
- Warts
- Tattoos
- Blood Coagulation (Hemophilia)
- Auto-immune disorders (Lupus)
- Fitzpatrick Skin Types IV, V, VI
- Patients with an implanted pacemaker
- Patients with metal or electrically conductive implants
- Cancer
- Eye regions/eyelids

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- Cardiac disorders or cardiovascular diseases
- Uncontrolled Diabetes
- Circulatory Disorders
- Active Herpes or Shingles
- Skin Disorders including psoriasis, eczema, dermatitis, Vitiligo
- Scars including hypertrophic, keloid scars or previous occurrences of keloid scars
- Pregnancy and breastfeeding

PRECAUTIONS

Consult with the patient on the following:

- Toxins, chemical peels, retinols, and/or dermal fillers in the treatment area
- Topical Anesthetic Intolerance
- Recent surgical procedures
- Hyperpigmentation
- Uncontrolled Epilepsy
- Anemia
- Medications or herbal supplements
- Eye conditions or prior surgeries/treatments
- Contact lens use during and after procedure is not recommended

POTENTIAL SIDE EFFECTS

Possible complications of PLASMA IQ treatment are similar to other types of skin resurfacing procedures and include delayed healing, scarring, swelling, redness and skin discoloration. PLASMA IQ technology is to be used in patients with light to medium skin complexions. The risk for skin discoloration may be higher in patients with darker skin.

Potential complications related to energy-based treatments such as use of PLASMA IQ include:

- Swelling and Bruising
- Skin discoloration
- Redness and tenderness
- Scarring
- Scabbing and crusting
- Infection

PRE-CARE RECOMMENDATIONS

Avoid sun exposure or tanning beds for 2-4 weeks before treatment.
Ideally, begin applying sunscreen for 2-4 weeks before treatment.

POST-CARE RECOMMENDATIONS

- There may be stinging in the treated area immediately following treatment. This is normal and typically lasts for about an hour, but some variation in time may occur.
- **DO NOT pick at or scratch** at scabs during the healing phase, which **typically lasts 5-7 days** as this may delay healing or affect outcomes.
- **Avoid touching or cleansing the area** for at least **12 hours after the procedure**. In case of infection, consult with your physician.
- Continue to **apply moisturizer** or occlusive balm (e.g. petroleum jelly) during the healing phase twice daily after gentle cleansing.to the skin with hypoallergenic soap (e.g. CeraVe sensitive skin or Cetaphil gentle skin)
- Avoid sunlight, exercise, heat, steam, or sweat for **48 hours after the procedure.** After 48 hours, apply sunscreen to the treated area daily.

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- **DO NOT use makeup** or products other than sunscreen/moisturizer/occlusive balm on the treated area until scabs have fallen off. May consider use of tinted sunscreen to substitute for concealer makeup
- Please also review the product label in consultation with your treating physician if questions/concerns.

MEDICAL HISTORY

I have informed the medical provider of all my known allergies and all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, antiplatelet or anticoagulation medications. I have been advised about which of these medications I should avoid taking on the days surrounding the procedure. I understand that the medical provider will rely on my documented medical history, as well as other information obtained from me in determining whether to perform this procedure. I have provided and agree to continue to provide accurate and complete information about my medical history and conditions. I herein state that I am not pregnant or nursing and do not have any contraindication to this procedure.

FOLLOW-UP TREATMENT

I agree to follow up with the medical provider at the recommended intervals at the Valley Health Clinic office location(s) and to contact the clinic if there is any change in my condition, medical history or any problem I may experience. I agree to call the office immediately and/or use the after hours number _____ should any unusual side effects occur. I understand that in case of a medical emergency, I should call 911 or go to an emergency medical facility.

CONSENT FOR TREATMENT: I _____(Patient NAME) herby voluntarily request _____(Medical Provider/Injector NAME) who is a licensed clinician to provide elective, aesthetic treatment. The procedure has been explained to me and my questions regarding such treatment, its alternative, its complications, and its risk have been answered. The information provided is clear and I understand the risks/complications of the treatment. My questions have been fully answered and I have read this document to understand its contents. I understand that there are no guarantees, all sales are final, and payment is due at time of treatment. I understand that I will continue to age and may need additional treatments/products in the future. I understand that aesthetic treatments are not going to take care of all my aging skin needs. I hereby give my unrestricted informed consent for treatment of designated aesthetic procedure/product. I also understand that this consent is valid for future treatments unless the policies of the office or the known risks for the procedure/product change. By signing this form I acknowledge that guarantees as to the final results of my treatment have not been made.

Initials: _____ I release the device manufacturer, medical provider/injector(s), and staff of Valley Health Clinic LLC and Revive Aesthetics LLC from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products.

Initials: _____ I authorize before, during and after the procedure(s) the taking of photographs to be part of my patient profile that may be used for educational, promotion or advertising purposes without disclosing my identity. I also release Valley Health Clinic LLC and its associated staff including Revive Aesthetics LLC from any liability in connection with the use of such photographs and/or videos. My name will not be used to identify these photographs without my written approval.

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