RejuvaPen Consent Form

Prior to receiving this treatment, I have been candid in revealing any condition that may have a bearing on this procedure, such as:

Pregnancy/nursing
Allergies
Diabetes
Use of Retin-A, glycolic acids, Accutane
Recent facial peels or surgery
Tendencies to cold sores/fever blisters
Hormonal Therapy
Botox (within 10 days) or Fillers (within 30 days)

RejuvaPen may not be used directly on any of the below conditions. I have disclosed any of the health concerns below that apply to me:

Open sores or lesions
History of skin cancer
Active acne (unless used with GFs)
Eczema
Broken/irritated skin, including conditions such as hives or dermatitis
Any stage of melanoma
Rosacea (unless used with GFs)
Raised surface
Any type of skin infection

- I understand there are no guarantees to this procedure.
- I understand there may be some degree of minor discomfort (scratchiness, itchiness and bruising).
- I understand that to achieve maximum results, I will need several ongoing treatments and will need to use daily products to heal and protect my skin.
- I understand that the possibility of irritation and redness exists and that I should notify my skin care professional if irritation persists.
- I will follow the home care program specifically designed for me without changing or adding any products without consulting with my skin care professional.
- I agree to all of the above to have this treatment performed on me and will follow all prescribed directions regarding post treatment care.

- I _____ (patient's name) understand the REJUVAPEN will be used to treat skin tightening, acne scarring, wrinkles or lift/firm the skin. I have been examined by my physician and have been cleared for this procedure.
- I understand that most patients look as though they have a moderate to severe sunburn and my skin may feel warm and tighter than usual. Most patients usually recover within 24 hours or less, but sometimes redness may persist for several days. Because the device may penetrate the skin there can be risk of infection. If this occurs, a follow up appointment will be required for further treatment.

The above points of information have been specifically discussed and made clear and I have had the opportunity to ask any questions concerning this information.

I now authorize _____ to begin my treatment with REJUVAPEN

Patient Name:_____

Patient Signature:_____Date:_____

Aesthetician Signature:_____