MOTYKIE medspa
By Board Certified Plastic Surgeon, DR. GARY MOTYKIE

PIXEL SKIN RESURFACING
CONSENT

Name of Patient: _____D.O.S_____

I authorize Motykie Med Spa to use the Harmony Pixel 2940nm Er:Yag system to perform fractional ablative skin resurfacing and any post treatment medical requirements that may be necessary.

I understand that the Harmony Pixel is a laser device designed for fractional ablative skin resurfacing and that clinical result may vary in different skin types. I understand there is a possibility of short-term effects such as reddening, blistering, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me.

Clinical results may vary depending on individual factors, including medical history, amount of sun damage or textural problems, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment.

I understand that treatment by the Harmony Pixel 2940nm Er:Yag system involves a series of treatments and the fee structure has been fully explained to me.

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 am not pregnant at this time, and that I have not taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator. I also have completed a medical history checklist and been informed about what I must do and "not do" before, during and after the series of treatments.

PHOTOGRAPHS: I do ___ I do not ___ give permission for photographs and other audio-visual and graphic materials to be used by the physician or MotkieMedSpa, for marketing, education-promotion purposes. Although the photographs or accompanying material will not contain my name or any other identifying information, I am aware that I may or may not be identified by the photos.

I do understand that before and after photos must be taken to monitor treatment progress.

I certify and agree that this constitutes full disclosure. I certify that I have read and fully understand the above information and that I had sufficient opportunity for discussion and/or to ask any questions. I accept the risks and complications of the procedure.
I certify I have received the Pre and Post instructions for the Pixel Skin Resurfacing.

Patient's Signature: _____Date:_____

Witness's Signature: _____Date:_____