# Opus Plasma Consent form

Name:_____ Age:_____
Address:_____
Home Phone:_____ Cell:_____
Referred by:_____

Have you ever had the following?

- ☐ Current or history of cancer, especially malignant melanoma or recurrent non-melanoma skin cancer, or precancerous lesions such as multiple dysplastic nevi
- ☐ Any active infection.
- ☐ Diseases: Herpes Simplex, Systemic Lupus Erythematosus, or Porphyria.
- ☐ Immunosuppressive diseases, including AIDS and HIV infection, or use of immunosuppressive medications
- ☐ History of bleeding coagulopathies, or use of anticoagulants
- ☐ History of keloid scarring
- ☐ Very dry skin.
- ☐ Exposure to sun or artificial tanning during the 3-4 weeks prior to treatment
- ☐ Are you pregnant?
- ☐ What medications are you taking (including aspirin)? _____
- ☐ Daily consumption of alcohol:_____
- ☐ Allergies:_____
- ☐ Are you taking any herbal preparations? (St. John's Wort, etc.).
  If yes, list:_____
- ☐ Do you wear contact lenses?

Skin type (when exposed to the sun without protection for about 1 hour):

- ☐ always burns, never tans
- ☐ always burns, sometimes tans
- ☐ sometimes burns, sometimes tans
- ☐ always tans
- ☐ Hispanic
- ☐ Asian
- ☐ Mediterranean

- ☐ Middle Eastern
- ☐ Black

When were you last exposed to the sun (including tanning booth)?_____
Do you use chemical sun tanning lotions?_____
Are you planning a holiday in the sun?_____
Reason for visit (area to be treated):_____
Prior treatment (if any):_____

Regenerate Laser Medspa

1. I have requested that the undersigned physician at the Clinic perform the following procedure (Opus Plasma)

2. Risks. There are risks related to the performance of this procedure. I understand and acknowledge that the risks that may occur in connection with this Procedure may include the following:
a. Discomfort and pain - I acknowledge that I will experience some discomfort during and after the Procedure.

b. Infection - Although rare, infection is a possibility any time a procedure is performed. I acknowledge and understand that although even more rare, it is possible for an infection to become a blood-borne widespread infection.

C. Blood clots in veins and lungs - Although extremely rare, it may be possible to develop a blood clot associated with this treatment that goes (embolizes) to the heart and/or lungs.

d. Allergic reactions - Although uncommon, I could possibly develop an allergic reaction to medicines applied to the treated area and that I could possibly develop an allergic reaction to any medications that may be prescribed for me.

e. Bruising - Bruising in the treated area is possible, especially if, within the last ten (10) days, I have taken aspirin or aspirin-containing products, or other medications that "thin" the blood.

f. Blindness and eye damage - The device used in the procedure, without protective eyewear, may cause visual loss including blindness. I understand that I will be provided with protective eye shields. Acknowledge that it is important to always keep these

shields on during the Procedure and that I should also keep my eyes closed to protect my eyes from accidental laser exposure.

9. Painful or unattractive scarring - Scarring is a rare complication of laser assisted treatment, but scarring is possible because the skin surface is disrupted by the laser. To minimize the chances of scarring, it is most important that I follow all postoperative instructions carefully.
h. Pigment changes (skin color) - During the healing process, the treated area may become either lighter or darker in color than the surrounding skin. This is usually temporary, but on a rare occasion, it may be permanent.
i. Poor healing - The resultant open wound may require more than the usual one to three weeks to heal.

3. Contraindications. I acknowledge that I have been informed of certain conditions that must be met for me to have the Procedure performed, some of which are as follows:
a. Pregnancy. I am not pregnant and have had a pregnancy test within the past 24 hours.
b. Age. I am between the ages of 25 and 65.
c. Oral Antiviral Agents. If applicable [explain when applicable) I have taken prophylactic oral antiviral agents for the prevention of Herpes Simplex Virus.
d. Other. I have had other contraindications, warnings and precautions explained to me by the Clinic and I agree that none of the contraindications apply to me, and I agree to comply with all such warnings and precautions

4. No Guarantee of Success. I recognize that this procedure is not an exact science and I acknowledge that no guarantees or assurances have been made to me as to the results that will be achieved. It is possible that multiple Procedures may be required and that even then success may not be achieved.

5. Consent to Photography. For the purposes of accurate record keeping in connection with the care and treatment which I am receiving and will subsequently receive from the Clinic, I hereby consent to have the Clinic's staff take before, during, and after treatment close-up photographs of the involved area (s) and the anatomical region surrounding the involved area (s). These photographs shall be used for medical records only and shall be treated with the same confidentiality as the remainder of my record at the Clinic

I have been given an opportunity to ask questions about my condition, alternate forms of anesthesia (if applicable) and treatment, the procedure to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent. By signing below, I certify that I have read and fully understand the contents of

this document and that I have received and understand all the disclosure referred to herein. I certify that I am a competent adult of at least 18 years of age. I voluntarily consent and authorize this procedure to be performed by _____ affiliated with Regenerate Laser Medspa performing the Procedure.

Signature of Patient:_____
Print Name of Patient:_____

Signature of Physician:_____
Print Name of Physician:_____
Date:_____