

## Informed Consent Aurora Skin Rejuvenation

**Patient name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Treatment sites** \_\_\_\_\_

**I duly authorize \_\_\_\_\_ to perform the Aurora Skin Rejuvenation procedure and any other measures which in their opinion may be necessary.**

I understand that the Aurora is a device used for skin rejuvenation and that clinical results may vary in different skin types. I understand there is a possibility of rare side effects such as scarring and permanent discoloration as well as short-term effects such as reddening, mild burning, temporary bruising and temporary discoloration of the skin. These effects have been fully explained to me \_\_\_\_\_ (patient's initials)

Clinical results may vary depending on individual factors, including medical history, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment.

I understand that treatment by the Aurora Skin Rejuvenation system involves a series of treatments and the fee structures has been fully explained to me \_\_\_\_\_ (patients initials)

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 consent to the taking of photographs and authorize their anonymous use for the purpose for medical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the consents of this consent form.

Patient signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_

Initial \_\_\_\_\_