Patient Consent Form for Tixel Treatment

This form is designed to provide you with the information you need to make an informed decision on whether or not to have a Tixel treatment performed. If you have any questions or do not understand any part of this consent, please do not hesitate to ask us.

I hereby authorize these clinicians to perform Tixel treatment on me. I understand that the procedure is purely elective and I have chosen to receive treatment for:

Treatment of _____ in this/these area(s): _____

Treatment of _____ in this/these area(s): _____

I understand the nature of my condition, the nature of the procedure, the alternative treatments available, and the benefits to be expected compared with alternative approaches. I understand that optimal results are achieved only with a series of treatments and that I will not see optimal results after one treatment. The need to complete a treatment plan has been fully explained to me.

Just as there are benefits to the procedure proposed, I understand that this procedure also involves risks. I understand that serious complications are very rare, but are possible. Common side effects include temporary slight swelling and “pinkness” (similar to a mild sunburn). The temporary side effects generally last a few hours, but may last 1-2 days. Bronze microspots usually appear after 1-2 days and will last 1-2 days until they flake off. For treatments with very aggressive settings, some patients might experience mild exudate and flaking/peeling of skin in the aggressively-treated area. Other potential risks include milia/acne or Herpes Simplex breakout, itching, pain, or minor infection. There is a rare possibility of burn, blistering, or erosion or a scar at the treatment site may develop.

I consent to photographs and videos being taken to evaluate treatment effectiveness and for medical education, training, advertising, and marketing.

“Before and After Instructions” have been discussed with me. The procedure, as well as potential benefits and risks, have all been explained to my satisfaction. I have had all my questions answered. I freely consent to the proposed treatment. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian/person having legal custody will also be required before treatment.

_____	_____	_____
Patient Signature	Print Patient Name	Date
_____	_____	_____
Clinician Signature	Print Clinician Name	Date