Dr. Steven Costalas
Kimberly Costalas, RN
4675A West Chester Pike
Newtown Square, PA 19073
484-420-4094

Clear Lift Consent Form

Patient Name _____

Treatment Sites_____

I duly authorize KP Aesthetics to use the Harmony Pixel Q-Switch 5x5 system to perform fractional non-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 non-ablative skin resurfacing and that the clinical result 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 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. ____initial

I understand that treatment by the Harmony Pixel Q-Switch system involves a series of treatments and the fee structure has been fully explained to me. ____initial

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. ____initial

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 that I am not using any medication or products not listed. I am not under any doctor’s care that I have not listed. I have disclosed any allergies or sensitivities I have had in the past. I have been informed about what I must do and “not do" before, during and after a series of treatments. ____initial

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

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

Patient Signature _____ Date_____

Provider Signature_____ Date_____