Desert Holistic Health PLLC
9188 E San Salvador Dr.
Suite 205
Scottsdale, AZ 85258
Phone: 480.336.4195
Fax: 602.914.7412
www.deserthh.com

I, _____ hereby authorize treatment (print name) by Megan Davies or whomever she may designate to perform Plasma Fibroblast Skin Tightening.

Possible side effects of these injections include but are not limited to:

- **Wound infection, scarring (extremely rare)**
- **Swelling, pain**
- **Hypersensitivity reaction to numbing cream**

- **I understand I should not be treated if I have a history of Keloid scarring, severe skin conditions, open wounds, severe acne, lupus, psoriasis or vitiligo. Also I should talk to my healthcare provider if I am on blood thinning medications or have been treated with Accutane within the last year.**
- **I attest I do not have a pacemaker/defibrillator**
- **If opioid or anti-anxiety medications have been prescribed to me I agree that I will not drive for 24 hours after taking the medication and should have a driver present at the appointment.**
- **I have not used Retinol within the past 14 days**
- **I attest I have considered alternatives to this procedure and that this has been discussed with the medical provider. I also attest that the procedure has been explained to me and I understand the downtime associated with this procedure.**
- **I agree to not pick at the dots post procedure as doing so could have permanent effects.**
- **I agree to wear sunscreen of SPF 45 or higher for 2 weeks post procedure and avoid the sun as well as abide by the aftercare instructions provided to me.**
- **I understand there will be swelling at the treatment site that can be severe. For this reason I understand upper and lower eyelids are sometimes treated at separate appointments.**
- **I understand that many people achieve results with one treatment but sometimes a second treatment is necessary. I understand that a second treatment will incur an additional cost.**
- **I understand that results are not guaranteed. In the event of unsatisfactory results I agree to be seen for a free consultation and discuss the best plan of action.**
- **I agree to contact the office in the event of any side effects I may incur from treatment, unless in the event of an emergency in which case I will call 911 or go to the closest E.R.**
- **I attest that I am not pregnant or nursing.**
- **I consent to taking of photographs during the procedure for educational purposes, marketing and for observing clinical response. Please initial here if choosing to opt out of marketing pictures _____**
- **I agree that all services provided are directly charged to me and that I am personally responsible for payment at time of treatment.**

By signing this consent form I am agreeing to be treated with the Plamere pen for Plasma Fibroblast skin tightening and have read the form in its entirety. I also release Megan Davies, whomever she may designate and Desert Holistic Health from any responsibility associated with the side effects mentioned above.

_____

(Sign name) (date)

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