LIGHTWAVE DERMAKINETICS CONSENT

Patient Name _____ DOB _____

LIGHTWAVE Therapy is a non-ablative cosmetic procedure which utilizes Light Emitting Diode (LED) technology to treat a variety of skin imperfections such as fine lines and wrinkles, scarring, blemishes, uneven skin tone and texture. The LIGHTWAVE treatment is a gentle and natural treatment much like the process of photosynthesis, also known as photo-bio-stimulation ("...the stimulation of life processes with light..."). The LIGHTWAVE system may use visible red (red light), blue (blue light) and infrared (invisible light) energy to stimulate your body's own regenerative metabolism at the cellular level. The Lightwave treatment will accelerate the production of collagen and elastin, increase cellular permeability, allowing for increased cellular nutrient intake. Increase the removal of excess fluid and waste products from the cells as well as increase vascularization (blood flow) to the surface of the skin.

LIGHTWAVE treatments are non-invasive and are intended not to produce any thermal damage or pain. Even though appropriate measures are taken to reduce side effects, they cannot be completely eliminated in every case. It is important to notify the treatment facility if you have any problems or concerns such as: Uncomfortable heat from the pad or panel, prolonged redness of the skin, or a headache during or after treatment. These are all indications of sensitivity to light in which case you would want to discontinue the treatment immediately. These side effects rarely occur and usually subside within 24 hours of discontinuing the treatment. It is also import to notify the treatment facility if any conditions to your medical history change such as becoming pregnant or diagnosis of a medical condition. To prevent any eye sensitivity, protective eyewear is to be worn if desired during all treatment sessions.

I understand that medicine is not an exact science and that no guarantees are offered regarding my expected results. I am aware that some individuals have excellent results, and that it is possible that this treatment will not work for me. I have read the above information and understand it. By signing this form, I hereby give my unrestricted informed consent for one or more Lightwave treatments. I understand that I release Facial Techniques and its associates, the Medical Supervisor, the technician performing services and any Facial Techniques employee involved in my treatment from any liability associated with complications from the Lightwave procedure.

I consent to be photographed before, during and after treatment. These photographs shall be the property of Facial Techniques. These photographs may be shown for scientific reasons, and/or used in patient education (both in and out of the office). I understand that I release Facial Techniques, the Medical Supervisor, the technician performing services and any Facial Techniques employee involved in my treatment from any liability associated with complications from the Facial Filler procedure.

I CONSENT TO THE TREATMENT OR PROCEDURE OF LIGHTWAVE DERMAKINETICS- LED.

SIGNATURE _____ DATE _____

WITNESS _____ DATE _____