Palm Beach PREVENTIVE MEDICINE | A Balanced Approach to Your Health.

Power Rejuvenator Pen (PRPen)

Treatment Consent Form

Patient Name: ____ DOB: _____________

Consent to Treatment – I voluntarily consent to receive medical and health services, depending on the degree of skin damage to the face and/or neck that may include but are not limited to:

- Treatment to exfoliate and smooth the skin.
- Treatment to help remove wrinkles and scars as well as rejuvenate tissue under the eyes, around the lips, and on the forehead.

Possible Adverse Events & Complications – I have been informed by the treating medical professional and understand that the treatment cannot be completed if I am pregnant and/or lactating (nursing) and has any of the following possible complications as a result of the treatment: discomfort, swelling, reddening, demarcation, blemishes, eye injury, scabbing, pigmentation, milia, infection, and scarring.

Possible Repeat Treatments – I understand that the treatment to be given is a skin rejuvenation treatment and I may need several administrations of the treatment. No guarantees are implicit in the treatment.

Financial Responsibility – I understand that this treatment is not covered by insurance. I agree to pay the treating facility the agreed upon fees for the treatment.

I authorize the treating office to discuss my medical care treatment with the following person(s).

Name: ___________________________ DOB: _____________ Relationship: _____________________

Name: ___________________________ DOB: _____________ Relationship: _____________________

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Patient signature: ____ Date: ______________________

Witness: ____ Date: ______________________