

**Highland Park Family Practice, LLC**

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**Patient name** \_\_\_\_\_

**Treatment sites** \_\_\_\_\_

**I duly authorize \_\_\_\_\_ to perform eMax treatment.**

I understand that the eMax is a device used for hair removal, skin rejuvenation, acne treatment, skin tightening; wrinkle reduction and non-ablative dermal remodeling, leg veins and other vascular lesions treatment, of which I am consenting to be a patient receiving \_\_\_\_\_ treatment (specify procedure).

I understand that clinical results may vary depending on individual factors, including medical history, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment.

I understand that there is a possibility of short-term effects such as reddening, mild burning, temporary bruising and temporary discoloration of the skin, as well as the possibility of rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me \_\_\_\_\_ (patient's initials).

I understand that treatment by eMax involves a series of treatments and the fee structure has been fully explained to me \_\_\_\_\_ (patient's initials).

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.

I confirm that I have informed the staff regarding any current or past medical condition, disease or medication taken.

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

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 \_\_\_\_\_

Witness \_\_\_\_\_