DESERT MEDICAL REJUVENATION
REGAIN YOUR YOUTHFUL APPEARANCE

ART QUINTANILLA MD
BOARD CERTIFIED PHYSICIAN

INFORMED CONSENT FOR DERMASWEEP TREATMENT

I hereby authorize **Arturo Quintanilla, MD/DBA Desert Medical Rejuvenation** to perform a DermaSweep Exfoliating Treatment. I understand the treatment may include an Epi-infusion of a skin solution geared toward treating my skin. The goal of DermaSweep as in any cosmetic procedure, is aesthetic improvement not perfection. I understand that my results may not be perfect. In the case of DermaSweep, the number of treatments necessary will vary among individuals and the areas being treated. _____**(Initial)**

DermaSweep is the most advanced non-invasive exfoliation procedure available today. The technology used for your procedure was developed in the United States and has been used in thousands of procedures. _____**(Initial)**

Indications for use for DermaSweep include the treatment of fine wrinkles, blackheads and whiteheads, sun-damaged skin, superficial age spots, oily skin, and for epidermal peeling of the face, neck and other parts of the body._____**(Initial)**

I understand that the following side effects or complications may happen to me: _____**(Initial)**

1. Discomfort
2. Acne Flare up
3. Transient spots of hypo or hyperpigmentation
4. Bruising
5. Redness and swelling for a period of 2 hours to 7 days
6. Itching or irritation
7. Skin peeling or flaking up to 7 days after the procedure
8. Infection
9. Herpes (fever blisters on face and lip)
10. Rarely scarring

The procedure involves the use of a vacuum to increase blood circulation in the treated area, and the DermaSweep wand to remove the epidermal layer of the skin in conjunction with an infusion of topical skin solutions. The combination of removing the epidermal layer and increasing blood circulation, stimulates collagen and fibrin formation to create a treatment of the affected area. _____**(Initial)**

The treatment fees have been discussed and I understand them. _____**(Initial)**

I confirm I am not pregnant, I have not used Accutane or other oral retinoid products in the past 12 months, and I have not used topical retinoid (Retin A, Differin, Tazorac) in the past month. _____**(Initial)**

I have informed my skin care provider if I have any of the following conditions: history of pigmentation disorder, history of keloid scarring, active herpes simplex, recent peels or laser treatment, recent sun exposure, autoimmune disease, any surgery in the past six months. _____**(Initial)**

I understand the DermaSweep procedure is controlled process, but it is not an exact science and the results cannot be guaranteed. I acknowledge that no guarantee has been made by anyone regarding the results of this

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treatment that I have requested and authorized. The physician or technician has provided the information and answered all my questions concerning this procedure. I clearly understand the above information. _____**(Initial)**

I consent and authorize the healthcare facility located at 35900 Bob Hope Drive Suite 130, Rancho Mirage, CA 92270, to take all necessary photographs before and after my procedure. _____**(Initial)**

Patient
Name_____

Patient Signature_____
Date_____

Witness
Name_____

Witness Signature_____
Date_____

Esthetician
Name_____

Esthetician Signature_____
Date_____

CONTINUED TREATMENT CONSENT

Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____
Date: _____	Initials: _____
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Date: _____	Initials: _____

Date: _____ Initials: _____

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