DERMATOLOGY
OF EASTERN IDAHO
MEDICAL SPA

703 Rigby Lake Dr, Rigby, Idaho | Phone: (208) 745-0200

CONSENT AND RELEASE FORM
DERMAPEN

Patient's Name (PRINT): _____

Address: _____

City: _____State: _____ Zip Code: _____

Home Phone: (_____)_____ Cell: (_____)_____

Email address: _____

To the patient:

It is important that you are informed about your skin condition and proposed treatment including the potential benefits and risks involved. This disclosure is not meant to scare or alarm you; it is simply an effort to better inform you so that you may give or withhold your consent to the treatment program.

I _____, of (address as above) have requested a Dermapen Treatment to attempt to improve my facial expression lines, skin tone and texture and/or scarring.

The practice of medicine is not an exact science and no guarantees can be or have been made concerning expected results. I understand that several appointments may be necessary to reach the desired results.

Risks and side effects:

Side effects and complications are usually minimal. Occasionally you may experience redness, bleeding, temporary scarring, dryness and or discomfort. I have been advised of the risks involved in such treatment, the expected benefits of such treatment, and alternative treatments, including no treatment at all.

I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I certify that I have read, and that I have had sufficient opportunity for discussion and to ask questions. I consent to this procedure today and for all subsequent treatments.

Patient's Signature: _____Date: _____

Operator's Signature: _____Date: _____