DERMATOLOGY
OF EASTERN IDAHO
MEDICAL SPA

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CONSENT AND RELEASE FORM
DERMASWEEP EPI-INFUSION TREATMENT

Please initial after each statement and sign at the bottom.

I, _____, hereby authorize _____, to perform a DermaSweep Micro-Resurfacing procedure. I understand the procedure 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; the number of procedures necessary varies among individuals and the areas being treated. _____
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. _____

I understand that the following side effects or complications may happen: _____

- Discomfort
- Acne flare up
- Transient spots of hypo and/or hyperpigmentation
- Bruising
- Redness and swelling for a period of 2 hours to 7 days
- Itching and/or irritation
- Skin peeling or flaking up to 7 days after the procedure
- Infection
- Herpes (fever blisters on face and lip)
- Rarely scarring

The procedure involves the use of a vacuum to increase blood circulation in the treated area, and the DermaSweep bristle tip 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 areas.

The procedure fees have been discussed and I understand them. _____

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 a topical retinoid (Retin A, Differin, Tazorac) in the past month. _____

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 treatments, recent sun exposure, autoimmune disease, and/or any surgery in the past six months. _____

I understand the DermaSweep procedure is a 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 procedure 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. _____

Patient's Signature: _____ Date: _____

Operator's Signature: _____ Date: _____