The Paragon Plastic Surgery & Med Spa
(817) 473-2120

Consent for Aesthetic Procedures

Full Name _____ **Date**_____

This is an informed consent document that has been prepared to help inform you of your non-surgical aesthetic procedure(s), its associated risks and alternative treatments. It is important that you read this information carefully and completely. Please read each word, sentence, paragraph, and page. Please initial each section and sign the consent for aesthetic procedure(s).

I voluntarily consent to and authorize The Paragon Plastic Surgery & Med Spa and all associated physicians, licensed aestheticians and other healthcare providers as deem appropriate, to treat my condition which has been explained to me as: understand that the following non-surgical aesthetic procedure(s) is planned for me, and I voluntarily consent, request, and authorize this procedure(s): [Circle or add as 'Other]

IPL/Photofacial	**NIR Skin Tightening**	**Laser Hair Removal**
Microdermabrasion	**Chemical Peel**	**Dermaplaning**
Tattoo Removal	**Laser Spider Vein Treatment**	**Laser 360**

Other_____

_____I understand the treatment may involve risks of complications or injury from both known and unknown causes and I freely assume these risks. **Possible risks include but are not limited to scarring, skin redness, skin irritation, swelling, discomfort, tenderness, pinpoint bleeding, bruising, pimple-like bumps, dry skin, lightening of the skin (hypopigmentation), and darkening of the skin (hyperpigmentation).** I understand these stated risks are those most relevant to an intelligent decision on my part, and the list of remotely possible material risks is nearly unlimited. I agree to adhere to all safety precautions and regulations during the procedure.

____I agree to allow photographs of the intended procedure site for diagnostic purposes and to enhance my medical record to follow progression of my treatment. I agree that these photographs will remain the property of The Paragon Plastic Surgery & Med Spa.

____I understand that my responsibility, as the patient, is to follow the post-procedure care instructions and to maintain regular office visits that are critical to the success of the procedure. I agree that I will notify The Paragon Plastic Surgery & Med Spa, as soon as possible, of any questionable conditions, complications, unusual symptoms or any questions that can arise.

____I understand that I have the right to refuse treatment.

____ Due to the nature of the treatment, exact results cannot be predicted and I acknowledge that no guarantees have been made to me as to the final or expected results that may be obtained. I further understand that no promises of permanence have been made to me regarding laser assisted hair reduction or skin care treatments.

_____I agree to pay for the above mentioned procedure and understand that there will be no refund. I also understand that subsequent revisional procedures will require additional costs.

_____THIS PARAGRAPH PERTAINS TO SMOKERS.
Smokers are recognized as having a significantly higher risk of post-procedure wound healing problems and complications including, poor or improper skin healing, increased bruising, and increased chance for infection.

_____I acknowledge that I have read and completed the new patient registration and medical history forms fully, correctly, and to the best of my knowledge and the information I have given to Bishara Cosmetic Surgery and Hair Restoration is complete and correct. I understand voluntarily or involuntarily withholding medical information can lead to complications or problems that may have been prevented if that information were known prior to my procedure.

_____The Paragon Plastic Surgery & Med Spa and all associated physicians, licensed aestheticians and other healthcare providers as deem appropriate, have fully explained in terms clear to me the nature of the procedure(s) to be performed, the foreseeable or common risks and complications, and alternative methods of treatment. Lastly, I acknowledge that I have been given an opportunity to ask any questions I desire regarding the diagnosis and procedure(s) and that these questions have been fully explained to me in layman's terms. I have read this document and I understand its contents. I hereby give my unrestricted informed consent for the procedure. I further state that I fluently read, write, and speak English.

_____THIS PARAGRAPH PERTAINS TO FEMALE PATIENTS ONLY. Anesthetic agents or any other medications can be harmful to the fetus or a pregnant woman. General anesthesia should be avoided during pregnancy whenever possible. I herby state that I am not pregnant and agree to a urine pregnancy test prior to my surgical procedure. You will be given a pregnancy test at your two week preoperative appointment and another on the morning of the procedure. If you have a positive pregnancy test, your procedure will be cancelled with the option to reschedule, and you will be charged a $30 administrative fee at that time.

_____THIS PARAGRAPH PERTAINS TO SMOKERS Smokers are recognized as having a significantly higher risk of postoperative wound healing problems and complications, as well as operative and postoperative bleeding. Some complications that are at a higher risk due to smoking include: bleeding, infection, blood clots in the legs and or lungs,, poor healing, increased bruising, wound breakdown, wound and chest infections, pneumonia, thrombosis, and heart and lung complications. Patients must discontinue smoking at least 6 weeks prior to and after surgery. Although it helps to stop smoking for several weeks before and after surgery, this does not eliminate the increased risk resulting from long-term smoking. You will be given a tobacco urine test at your two week preoperative appointment, the morning of the procedure and during the postoperative period if doctor warranted. If you test positive for tobacco the procedure will be cancelled with the option to reschedule after a clean tobacco test during the preoperative period, and you will be charged a $30 administrative fee at that time.

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Patient Signature: _____ **Date:** _____

Aesthetician Signature: _____ **Date:**_____