PICOWAY INFORMATION AND CONSENT

ABSOLUTE
COSMETIC MEDICINE

ONLY SIGN IF YOU FULLY AGREE AND UNDERSTAND

This form is designed to give you the information you require to make an informed decision to undergo treatment. If you have any questions before the treatment, please feel free to ask.

I _____ have received the following information about the PicoWay
Printed Name

I understand that the PicoWay is a device used for removal of benign pigmented lesions and tattoos, 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 but not limited to medical history, skin type, patient compliance with pre and 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 discolouration of the skin, as well as the possibility of rare side effects such as permanent discolouration. These effects have 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. 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 of any current of past medical condition, disease or medication taken.

I cannot dispute what I have read, agreed to and signed above. If I do then I agree to pay all costs incurred by ACM if I breach this agreement. I agree to follow the ACM social media policy and pay all costs incurred by ACM if I breach this policy. I understand that photographs are for clinical use only. I am responsible for taking my own photographs for my records.

_____
Patient's Initials

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this form.

_____ _____
Patient Signature *Date*

_____ _____
Witness Signature *Date*