ENFUSE
MEDICAL SPA & HAIR RESTORATION

CUTERA®

Cutera XEO Skin Rejuvenation AFT/IPL Photofacial

Patient Name: _____

Area of Concern/Treatment:_____

_____

I duly authorize ENFUSE Medical Spa and Laser Center to perform Skin Rejuvenation utilizing the Cutera XEO AFT/IPL Photofacial technology.

I understand that the AFT/IPL Photofacial is a device used for skin rejuvenation and that clinical results may vary in different skin types. I understand that there is a possibility of short-term effects such as:

- Reddening
- Blistering
- Scabbing
- Temporary Bruising and/or Discoloration of the skin

Additionally rare side effects have been known to occur such as:

- Scarring
- Permanent Discolorations

Clinical results may vary depending on individual factors, including medical history, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment. I understand that treatment with the Harmony AFT/IPL Photofacial system involves a series of treatments and the fee structure has been fully explained to me.

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and 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 am not pregnant at this time and that I have not taken Accutane with the last six months. I do not have a pacemaker or internal defibrillator. I consent to the taking of photographs and authorize their anonymous use for the purpose of medical audit. I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent.

Patient Signature:_____

Date:_____/_____/_____

Staff Signature:_____