ENERJET™/AIRGENT™ System

PATIENT'S NAME: ________________________ DATE: _________________

SPECIAL CONSENT FOR ENERJET™/AIRGENT™ TREATMENT

This form is designed to give you the information you need to make an informed choice of whether or not to undergo treatment with the EnerJet™/Airgent™ System. If you have any questions before your treatment, please feel free to ask.

The EnerJet™/Airgent™ System is used in the treatment of lax skin, wrinkles, acne scars and other areas of the dermis that are becoming void of their natural ability to absorb water from the body. This system pneumatically emits an intense, high-pressure surge of a selected and controlled mixture of Hyaluronic Acid (known as HA) and Saline that is forced through the epidermis.
Over the next couple of days the HA will spread within a 1-cm square area of the dermis where it will settle and begin to absorb water, allowing the increase of volume to the skin by offering a "plumping effect".

Immediately following the treatment the areas treated will be surrounded by a raised skin colored bump with a small red entry point that will also typically resolve over the next couple of days. In the following few days of treatment it is advised to increase your daily intake of water in order to assist the newly administered HA in the rehydration process of your skin. Do not pick or scratch any of the direct treatment areas.

Complications from EnerJet™/Airgent™ treatments are uncommon but may occur. These can include hyperpigmentation, unsatisfactory or inadequate improvement, infections, temporary bruising or post traumatic vascularities from HA entry points.

Initial Here

______ The procedures to be used to treat my conditions have been explained to me.

______ I have been informed that there are risks associated with the procedures.

______ I know and understand that the practice of medicine and surgery is not an exact science and I acknowledge that no warranty or guarantee, expressed or implied by anyone, has been made to me as to the result or cure.

______ I consent to the administration of anesthetics and other medications as considered necessary.

______ I have had sufficient opportunity to discuss my condition and treatment. I believe I have adequate knowledge upon which to base an informed consent.

______ I understand that it may take 3-5 treatments to see maximal benefits over a 1-2 year time frame..

______ I understand that any type of scar is permanent and this treatment can improve, but not eliminate them.

______ I understand that any treatment provided may/or may not meet my expectations. I understand and agree that there is no compensation or refund of monies paid in any event.

______ I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

Please Print Full Name Legibly	Patient Signature	Today's Date: DD/MM/YYYY	Dr. Matta

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Please Print Full Name Legibly	Patient Signature	Today's Date: DD/MM/YYYY	Dr. Matta