DESERT MEDICAL REJUVENATION
REGAIN YOUR YOUTHFUL APPEARANCE

ART QUINTANILLA, M.D.

INFORMED CONSENT FOR PLEXR PLASMA PEN

Plexr is the most developed non-invasive device that uses technological innovation based on plasma energy to replace surgery, thus marking a new direction in aesthetics. It represents the so-called soft surgery with the results such as those obtained by surgery .
Soft surgery Is an aesthetic to medical-surgical practice, which is noninvasive, bloodless, reliable and safe, easy to perform and without serious risks; effective for all skin types.

CONTRAINDICATIONS

- Pregnancy/breastfeeding
- Metal plates , pins or other implants
- Cardio-vascular conditions: uncontrolled B/P, pacemaker, CV electrical devices
- Current or recent hemorrhage
- Malignancy
- Susceptible to hypertrophic scarring or keloid formation
- Immune suppression disease or autoimmune disease

PLEASE INITIAL HIGHLIGHTED AREAS

I understand this treatment may not meet my desired needs or expectations and I further understand that favorable results with PLEXR PLASMA PEN requires a series of 3-4 treatments spaced 3-4 weeks apart. It is my responsibility to schedule these appointments. _____**(Initial)**

I consent to and authorize the healthcare facility, Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270, to perform this procedure._____**(Initial)**

I consent to and authorize the healthcare facility, Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270, to take all necessary photographs before and after my procedure. _____ **(Initial)**

The nature and effects of the procedure, the risks and complications, if any involved, and other alternative methods of treatment have been fully explained to me. I understand them, and I assume all responsibilities. _____ **(Initial)**

All before and after care instructions have been explained and given to me. I understand my responsibility of properly following these instructions to minimize any risks of complications._____ **(Initial)**

I have had the opportunity to ask any questions about the treatment including risks or alternatives and acknowledge that all my questions about the procedure have been answered in a satisfactory manner and that all blanks were filled prior to my signature. _____ **(Initial)**

When completing the medical questionnaire, I have answered the personal medical history questions fully and to the best of my ability. _____ **(Initial)**

I declare to have obtained suitable information on the diagnosis, prognosis, prospects and eventualities diagnostic - therapeutic alternatives and on the foreseeable consequences of the choices made, during the visit

I understand that results will vary between individuals. I understand that although I may notice a change after my first treatment; I may require multiple sessions to obtain my desired outcome. _____**(Initial)**

I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the success or other result of the treatment. _____**(Initial)**

I understand that this treatment is strictly for cosmetic purposes and will not be covered by insurance. I understand that I am responsible for all costs payable at the time of services. _____ **(Initial)**

The cost of the procedure involves charges for the services provided. The total includes fees charged by Desert Medical Rejuvenation, 35900 Bob Hope Drive Suite 130 Rancho Mirage, CA 92270, the cost of supplies and other related expenditures. Should complications develop from the procedure additional costs may occur and will be the patient's financial responsibility. Additional procedures, supplies, antibiotics, etc. will also be the patient's responsibility. _____ **(Initial)**

I understand that all services that have been rendered are non-refundable. _____ **(Initial)**

By my signature below, I certify that I have read and fully understand the contents of this permission form. I was given the opportunity to have Desert Medical Rejuvenation address any questions or clarifications that I might have prior to signing the consent and thereby grant permission to perform Plexr Plasma Pen on me by Desert Medical Rejuvenation.

Patient Name:_____

Patient Signature: _____ DATE: _____

Witness Name: _____

Witness Signature: _____ DATE:_____

Translator Name: _____

Translator Signature: _____ DATE: _____

Physician Name:Art Quintanilla MD_____

Physician Signature: _____ DATE:_____