

CONSENT FORM FOR PLASMAJET TREATMENT

- 7. Do you have a history of keloid scar formation?
- 8. Do you have a history of poor wound healing?
- 9. Do you have diabetes?
- 10. Are you currently using steroid containing medication?
- 11. Do you have high blood pressure or heart disease?

Y	N
Y	N
Y	N
Y	N
Y	N

Risks and side effects:

While PlasmaJet treatment is generally safe, potential risks and side effects include:

- Redness, swelling, or discomfort in the treated area
- Scabbing or crusting of the treated skin
- Temporary skin sensitivity
- Hyperpigmentation or hypopigmentation
- Infection at the treatment site
- Allergic reactions to topical numbing agents or post-care products

Y	N

Precautions and aftercare:

- Inform your healthcare provider of any medical conditions, including skin conditions such as eczema, rosacea, or psoriasis.
- Discuss any medications you are taking, including prescription and over-the-counter medicines, vitamins, and herbal supplements.
- Avoid sun exposure and tanning beds for at least 24 hours before the procedure.
- Avoid using retinoids and other potent skincare products for several days before the procedure.

Y	N
Y	N

Post-care instructions

Follow the post-care instructions provided by your healthcare provider.

- Avoid sun exposure and use a broad-spectrum sunscreen with at least SPF 30.
- Avoid strenuous exercise, saunas and steam rooms for 48 hours post-treatment.
- Avoid using makeup, retinoids and other potent skincare products for a specified period as advised by your healthcare provider.

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Financial Responsibility: I understand that I am financially responsible for the Plasma jet treatment cost of sessions as discussed with the clinic.

Patient Consent: I have read and understand the above information about PlasmaJet treatment. I have discussed the procedure with my healthcare provider and have had all my questions answered to my satisfaction. I understand the risks and benefits associated with PlasmaJet treatment and agree to proceed with the treatment.

Signature of Patient: _____

Date: _____

Signature of Healthcare Provider: _____

Date: _____