



Beauty laser & wellness center  
Monica Bonakdar, MD

## Pellevé™ Consent Form

*This form is designed to provide you with the information you need to make an informed decision on whether or not to have the Pellevé™ Treatment performed. If you have any questions or do not understand any part of this consent, please do not hesitate to ask us.*

**TREATMENT-** I have requested treatment on the following areas:

Face       Neck       Chest       Hands       Partial Face: \_\_\_\_\_

### **Pellevé™ System**

Ellman's Pellevé™ Wrinkle Reduction System FDA approved for the non ablative treatment of mild to moderate facial wrinkles and rhytids on skin colors I-IV. Pelleve studies indicate that greater than 85% of patients still have observable results six months after treatment.

**FULL CORRECTION-** I understand that a full correction may take several treatments to accomplish and there is a charge for all additional treatments done.

- I want full correction and I am willing to do more than one treatment.
- I only want one treatment. (Please inform Dr. Bonakdar)

### **CONTRAINDICATIONS-**

- I do not have a pacemakers or any implantable devices.
- I do not have diabetes, autoimmune disorder, or history of cold sores..
- I am not pregnant and I am not breastfeeding.
- I am not using Accutane nor have I been on Accutane in the last year.
- I do not have nerve insensitivity to heat in the treatment area.
- I do not have any cuts, wounds or infections in the skin area be treated.

**HERPES SIMPLEX-** Herpes simplex eruption may result in rare cases in a treated area that has previously been infected with the virus. This reactivation can be avoided by taking an Anti-viral prior to the procedure. . I understand that if I have ever, in my life, experienced a cold sore in the area of my treatment, I must start on an antiviral prophylaxis and I can get a prescription from this office by requesting the medication.

**SIDE EFFECTS-** Studies indicate that side effects are minimal and limited to treatment site. These may include mild discomfort during treatment and mild swelling and redness after treatment that resolve spontaneously in 2 to 24 hours.

**Static Shock Discharge-** Much like the static shock one feels when touching rubbing their feet on the carpet and then touching something, I understand that I may feel an electric shock when the electrode makes contact or is removed from my skin.

In order to lessen this possibility

- All jewelry must be removed prior to treatment.
- All makeup, including lotions and eye makeup must be removed.
- Eyelid treatments must be done with corneal eyeshields
- Beard stubble must be completely removed

There is the possibility that additional risk factors of radiofrequency skin treatments may be discovered. The effects of having Pellevé™ wrinkle treatments in combination with other treatments is unstudied and unknown.

**AUDIO AND VIDEO RELEASE-** Pre and Post-Treatment photos, video and audio may be taken of the treatment for record purposes. I understand that these photos will be the property of Dr. Bonakdar. These photos may be used for diagnostic, educational, advertising, or record keeping purposes; however the material will not contain my name or any other personal identifying information.

**NO GUARANTEES-** Because all individuals are different, it is not possible to completely predict the benefits from this treatment. By signing this form I acknowledge that guarantees as to the final results of my treatment have not been made. Some individuals will have a very noticeable improvement after the first treatment, while others may have little or no improvement. I understand that additional treatments for additional fees may be needed to achieve my desired end result.

**NO REFUNDS-** This office has a strict no refund policy. This means that no refunds are given on procedures performed for any reasons.

*By my signature, I acknowledge that I have read the foregoing informed consent form and have been adequately informed of the nature of my condition, the nature of the procedure, the expected benefits of this treatment, the risks of this treatment, the alternative methods of treatment, and the risks of not treating my condition. I hereby consent to this procedure.*

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Staff Signature \_\_\_\_\_ Date \_\_\_\_\_