South Hills Eye Associates, Ltd and RevEyev, LLC Informed Consent

713 Washington Road, Pittsburgh PA 15228

LUMECCA * LUMECCA-I * FORMA-I * Morpheus8 * Meibomian Gland Expression Treatments

Patient Name: _____

Treatment Sites: _____

I duly authorize _____to perform _____ treatment.

I understand that the device(s) and technology(ies) being used is/are for any or all of the following: ocular surface disease, meibomian gland dysfunction, ocular rosacea, blepharitis, demodex, skin rejuvenation, skin tightening and/or dry eye disease, of which I am consenting to be a patient receiving _____ treatment.

I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre and post-treatment instructions, and individual response to treatment.

I understand that there is a possibility of short-term effects such as reddening, mild burning, temporary bruising, and discoloration of the skin, as well as the possibility of rare side effects such as scarring and permanent discoloration. The most common side effects and complications of the procedure are pain, swelling, bruising, blistering, burn, pigmentary changes, scarring, allergic reactions, infection, and herpetic eruptions (in carriers of the herpes virus). These effects have been fully explained to me. **Patient initials** _____

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 result obtained. In the event that my condition is of cosmetic concern, I attest that the decision to proceed is based solely on my desire to do so. I confirm that I have reviewed the contraindications checklist and informed the staff regarding any current or past medical condition, disease or medication taken. Furthermore, I will review the contraindications checklist and inform the doctor of any changes in my medical condition or medications prior to each treatment.

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

By signing this form, I agree that my insurance will not be billed. This is my advanced beneficiary notice of insurance non-coverage. Undergoing the proposed IPL (intense pulse light) and/or RF (radiofrequency) treatments are optional, and I am choosing to proceed and assume the complete financial obligation. **Patient initials** _____

Potential Contraindications Checklist

LUMECCA * LUMECCA-I * FORMA-I * Morpheus8 * Meibomian Gland Expression Treatments

- Surgery in the treatment area within the last 12 months
- Implants in the treatment area
- History of herpes. Patients with history of diseases stimulated by heat, such as recurrent Herpes simplex in the treatment area, may be treated only following a prophylactic regimen
- Urinary tract infection
- Current or history of skin cancer, or current condition of any other type of cancer or pre-malignant moles in the treatment area
- Significant illness such as diabetes, cardiac disease, autoimmune disease
- History of epidermal or dermal disorders involving collagen or microvasculature
- Active electrical implant in any region of the body
- Pregnancy and nursing
- Diseases of the immune system such as HIV, AIDS or immunosuppressive medication
- Use of anticoagulants or history of bleeding disorders
- Any active condition in the treatment area, such as open lacerations, infection, abrasions or lesions, psoriasis, eczema or rashes
- History of skin disorders, keloids, abnormal wound healing
- Tattoo in the treatment area
- History of Accutane use in the previous 6 months
- Having received treatment with light, laser, radiofrequency, or other devices in the treated area within 2-3 weeks for non-ablative procedures, and 6-12 weeks for ablative fractional laser resurfacing (according to the treatment severity) prior to treatment
- Use of non-steriodal anti-inflammatory drugs (NSAIDs, e.g., ibuprofen or similar containing agents) one week before and after each treatment session, as per the doctor's discretion
- Excessively tanned skin in the treatment area from natural sun, sunbeds or tanning creams

_____ _____

Patient Signature **Date**

_____ _____

Witness **Date**

FOLLOW UP VISITS:

Date	Patient's Signature