NoSweat Fort Wayne

Disclosure and Consent for Opus Fractional Plasma treatments

1. **The Procedure**. I have requested that Dr Rettenmaier or his designated associate at NoSweat Fort Wayne perform the Opus Fractional Plasma treatment on the following areas of my body: _____
_____

2. Risks. There are risks related to the performance of this Procedure. I understand and acknowledge that the risks that may occur in connection with this procedure may include the following:

a. Discomfort and pain – I acknowledge that I will experience some discomfort during and after the Procedure.

b. Infection – Although rare, infection is a possibility any time a Procedure is performed. I acknowledge and understand that although even more rare, it is possible for an infection to become a blood-borne wide spread infection.

c. Blood clots in veins and lungs –Although extremely rare, it may be possible to develop a blood clot associated with this treatment that goes (embolizes) to the heart and/or lungs.

d. Allergic reactions – Although uncommon, I could possibly develop an allergic reaction to medicines applied to the treated area and that I could possibly develop an allergic reaction to any medications that may be prescribed for me.

e. Bruising – Bruising in the treated area is possible, especially if, within the last ten (10) days, I have taken aspirin or aspirin-containing products, or other medications that "thin" the blood.

f. Painful or unattractive scarring – Scarring is a rare complication of Fractional Plasma assisted treatment, but scarring is possible because the skin surface is disrupted by the treatment. To minimize the chances of scarring, it is most important that I follow all postoperative instructions carefully.

g. Pigment changes (skin color) – During the healing process, the treated area may become either lighter or darker in color than the surrounding skin. This is usually temporary, but on a rare occasion, it may be permanent.

h. Poor healing – The resultant open wound may require more than the usual one to three weeks to heal.

3. Contraindications. I acknowledge that I have been informed of certain conditions that must be met for me to have the Procedure performed, some of which are:

a. Pregnancy. I am not pregnant.

b. Age. I am 18 years old or older.

c. Oral Antiviral Agents. If I have a history of Herpes, Cold Sores or Fever Blisters, I have taken prophylactic oral antiviral agents for the prevention of Herpes Simplex Virus outbreak.

d. Other. I have had other contraindications, warnings and precautions explained to me by the Clinic and I agree that none of the contraindications apply to me and I agree to comply with all such warnings and precautions.

4. No Guarantee of Success. I recognize that this Procedure is not an exact science and I acknowledge that no guarantees or assurances have been made to me as to the results that will be achieved. It is possible that multiple Procedures may be required and that even then success may not be achieved.

5. Consent to Photography. For the purposes of accurate record keeping in connection with the care and treatment which I am receiving and will subsequently receive from NoSweat Fort Wayne, I hereby grant permission to take photographs of myself, for medical records documentation and to publish those photographs for any lawful purpose, including, but not limited to, their website, social media accounts, and promotional materials, either digital or in print, in perpetuity.

By signing and dating this document I authorize Dr. Rettenmaier to edit, alter, share, remix, tweak, build upon or in any way alter the photograph(s) mentioned above. I also waive any rights of privacy or compensation associated with the use of my photographs for the personal or commercial purposes outlined above.

I have been given an opportunity to ask questions about my condition, alternate forms of anesthesia [if applicable] and treatment, the procedure to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent. By signing below, I certify that I have read and fully understand the contents of this document and that I have received and understand all the disclosures referred to herein. [I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian having legal custody will also be required before treatment. I voluntarily consent and authorize that this Procedure to be performed by Dr Rettenmaier or his designated staff member.

_____	_____
Signature of Patient	Physician (Provider)
_____	_____
Print Name of Patient	Print Name of Physician or Provider
Date _____	Date _____