SANTA MONICA
EYE MEDICAL GROUP

ENVISION LUMECCA CONSENT FORM

PATIENT NAME _____

TREATMENT SITES _____

TREATMENT
I understand that the device being used for _____ of which I am consenting to be a patient receiving LUMECCA 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 temporary discoloration of the skin, as well as the possibility of rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me _____**(patient's initials).**

I understand that treatment with this system involves a series of treatments, and the fee structure has been fully explained to me _____ **(patient's 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 final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. I confirm that I have informed the staff regarding any current or past medical condition, disease, or medication that was taken.

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

I agree to waive, release, discharge, and covenant not to sue Santa Monica Eye Medical Group and its employees, agents, and representatives from any liability, loss, cost, damage, expense, claim or lawsuit whatsoever for any and all injury, loss, illness, harm, cost, expense, or damage related to the treatment, including any negligent acts or conduct by Santa Monica Eye Medical Group and its agents, employees, and/or representatives (collectively, "Claims").

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.

Patient Signature_____ Date_____

Surgeon Signature_____

Witness_____