TheraClearX
ACNE THERAPY SYSTEM

Patient Consent Form

I understand that the TheraClearX is a photopneumatic technology that combines vacuum and broadband light for treatment of mild to moderate acne and that clinical results may vary based on patient. I understand there is a possibility of side effects and risks associated with my treatment which may include but are not limited to: erythema (redness), purpura, bruising, acne flare, superficial erosions, slight dryness and pigmentary changes (hyperpigmentation or hypopigmentation). These effects have been fully explained to me.

I understand that this process involves a series of treatments. I understand that multiple treatments are typically needed to achieve maximum results and that a single treatment may not provide a desired effect.

I understand that individual results may vary according to the following factors: medical history, skin type, area of the body treated, post-treatment care, and follow-up care. I will minimize these risks by adhering to the post-treatment care instructions given to me. I certify that I have been fully informed of the nature and purpose of this procedure, expected outcomes and possible complications and I understand that no guarantee can be given as to the final result obtained.

I certify that I have been given the opportunity to ask questions and that I have read and fully understood the contents of this consent form. I am aware of the importance of disclosing my complete medical history. I will notify staff of changes in my healthcare as they occur during my treatment process, including use of and changes in medications: both prescription and over the counter drugs, herbals, supplements, vitamins and birth control. I am completely aware of and have no further questions regarding possible side effects and risks associated with my treatment.

SIGNATURE _____ **DATE** _____