

Pixel Treatment Consideration

1. Indications: Skin resurfacing, scars- acne & full thickness, stretchmarks, enlarged pores, rough skin textured, hyperpigmentation, fine lines and wrinkles.
2. Anesthesia: There is no pain associated with a conservative or aggressive treatment. Therefore, no dyes or topical anesthetics are needed. During and post treatment cooling with the Zimmer Cryo 5 is used to minimize redness and sun burn feeling.
3. Size of Pixel: 7 x 7 tip for more aggressive and stacking treatments on scars, etc. 9x9 tip for periorbital, full passes and less aggressive treatments.
4. Depth of penetration: 20-50 microns ablation plus 75 microns thermal injury zones on single passes. Up to 150 microns on triple stacking.
5. Fluence on skin: conservative 600-800, moderate 1000, aggressive up to 1400 mj/pulse.
6. Number of passes: conservative 1, moderate 2, aggressive 3 passes plus stacking. When doing multiple passes, change direction- i.e. one pass horizontal and one pass vertical.
7. Stacking on problem areas: 2-3 pulses in the exact same place.
8. Time for full face treatment: 5-20 minutes.
9. Treatment areas: face, neck, chest, hands and body scars.
10. Down time on first treatment: redness and sun burn feeling for a couple hours or up to 2 days if aggressive. Pale (conservative) to dark brown (aggressive) pixel pattern and leathery feeling on days 3-5 with flaking. Swelling in aggressively treated areas through day 5. Full recovery by days 5-7. Down time is decreased with subsequent treatments. Since this is an Erbium, patients with more moisture in their skin experience more redness and sensation and greater results in fewer treatments. Therefore, a patient with dry skin may require more treatments.
11. Number of sessions: 3 for aggressive to 5 for conservative treatments at 2-4 weeks apart. Results will continue to improve once treatments are complete over 6 months.
12. Post treatment care: Immediately after treatment, apply wound healing product such as Humatrix or Biafine and cool with Zimmer. Send patient home with Aquaphor or equal to apply as needed for next 2 days. Instruct to only cleans, moisturize and use sunscreen for the next 7 days. Discontinue Obagi, RetinA, etc. regimen until day 7. On day 7 microderm or use an aggressive exfoliator or micro peel. Make-up can be applied to minimize pixel appearance.
13. Precautions: Do not Pixel over Botox or Restylane for two weeks post injection. Use an antiviral before treatments if there is a history of cold sores. Make sure skin is clean and dry before treatment.
14. Treatment price: \$500-\$800 per 20 minute session.

Harmony Pixel Consent Form

Patient name _____

Treatment sites _____

I duly authorize _____ to use the Harmony Pixel 2940nm Er:Yag system to perform fractional ablative skin resurfacing and any post treatment medical requirements that may be necessary.

I understand that the Harmony Pixel is a laser device designed for fractional ablative skin resurfacing and that clinical result may vary in different skin types. I understand there is a possibility of short-term effects such as reddening, blistering, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me _____ (patient's initials)

Clinical results may vary depending on individual factors, including medical history, amount of sun damage or textural problems, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment.

I understand that treatment by the Harmony 2940nm Er:Yag 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 am not pregnant at this time, and that I have not taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator. I also have completed a medical history checklist and been informed about what I must do and "not do" before, during and after the series of treatments.

I consent to the taking of photographs and authorize their anonymous use for the purposes 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.

Patient Signature _____

Date _____

Witness _____