Lumi Eyes Consent Form

Dermaren Lumi Eyes is a tissue stimulator designed for needle mesotherapy treatments around the eyes and the tear valley with a filling effect, but with no side effects in the form of lymphoedema. Lumi Eyes is a high-quality product that repairs damage to the dermis with polynucleotides with a strong tissue regenerating effect . The effect of the treatment is strong hydration and rejuvenation of the tissue, as well as the reduction of symptoms of fatigue and skin blueing.

Polynucleotide PDRN is used to regenerate damaged tissues, moisturise, restore volume, and smooth skin. PDRN is a low molecular weight complex that affects the repair of cells and damaged tissues, homeostasis from the inside. The mechanism of action of the substance is to stimulate the active synthesis of collagen, which helps to restore the DNA chains and increase the production of its own elastin. Glutathione, in turn, is responsible for the antioxidant effects during the biorevitalisation procedure.

Lumi Eyes is a high-quality injection product based on polynucleotides (obtained from purified salmon milk DNA) that repair damage to the dermis with tissue regenerating material. Ruthlessly destroys dark circles under the eyes, moisturises and fights fine wrinkles, as well as smoothing and lifting the skin under the eyes. As a tissue booster, it has a proven rejuvenating effect. Stimulation of the skin cells, collagen and elastin allows to delay the ageing processes and strengthens the skin. It improves the firmness, density and quality of the skin in an extremely natural way. Dermaren Lumi Eyes stimulates the skin to self-regenerate. Thanks to the absorption speed there is no downtime with this treatment, you can return to your normal daily life straight after the treatment.

Dermaren Lumi Eyes allows you to achieve a perfect effect after just one treatment. For better results, it is recommended to perform a series of 3 treatments with an interval of 4 weeks and repeat the treatment twice a year. The skin will gain energy and freshness, while reducing bruising and fatigue.

I have been advised of the relevant information associated with this treatment and I confirm that I fully understand this advice. This includes advice about:

- the aims/motivations for having the procedure and the desired outcome
- the risks inherent in the procedure

- the risks inherent in refusing the procedure
- the risks specific to me
- the expected benefits of the treatment
- the potential disadvantages of the treatment
- alternative procedures and their pros and cons - including the option of no treatment at all
- any uncertainties about and the likelihood of success of the procedure
- any follow-up treatment that may be required

CLINICAL PHOTOS AND VIDEOS: I agree to and authorise the taking of clinical photographs and videos. I understand that these clinical photographs and videos will form part of and will be kept with my confidential medical records.

I have been asked what information I want and would need in order to make an informed decision. I have been given the opportunity to discuss my desired outcome fully in order for me to make an informed decision.

I certify that I have read the above consent and that I fully understand it. I have been given ample opportunity for discussion and all my questions have been answered to my satisfaction. No new information has become available that affects my decision to have the treatment or my decision to consent. I hereby consent to this procedure. This constitutes the full disclosure and supersedes any previous verbal or written disclosures.

All deposits and booking fees are non-refundable unless agreed to with the practitioner.

Do you understand the information you have been provided? YES/NO

Do you feel sufficient information has been provided to you, to enable you to consent? YES/NO

Has your consent been freely given? YES/NO

Do you have any medical conditions? YES/NO

Are you pregnant or breastfeeding? YES/NO

Do you have a neuromuscular disease (e.g. MS, ALS, motor neuropathy myasthenia gravis, or Lambert-Eaton syndrome)? YES/NO

Do you have an autoimmune disease? YES/NO

Do you have any skin conditions? YES/NO

Do you have an allergy to fish/ are you vegan/vegetarian? YES/NO

Do you have any known allergies or have ever had anaphylaxis? YES/NO

Do you have any active infection at the intended site of procedure? YES/NO

Are you taking antibiotics or other prescription medications? YES/NO

Is there any other Medical and/or Social History that we should know?
If so, please provide full detail here.

What are your aims/motivations for having the procedure and the desired outcome? Please provide full details here.

Have you had this or a similar treatment before? If so, did you experience any problems? Please provide full details here.

Do you have any concerns? If so, please provide full details here.

Is there anything else we should know? Please provide full details here.

I will retain this information throughout the course of my treatment and refer to it as required.

SIGNED:
DATE: