INFORMED CONSENT
AESTHETIC TREATMENT WITH SKINRETIN XPERT PACK®

I, _____ with date of birth ___/___/___, and address at _____

With consent, I am happy to undergo the mesoestetic® **skinretin xpert®** treatment.

BRIEF DESCRIPTION OF THE TREATMENT

skinretin xpert pack® is a global anti-aging treatment designed to redensify, illuminate and revitalize the skin, improving texture and unifying skin tone. This treatment comprises as its principal active ingredient retinol, retinal, both active ingredients promote cell renewal and regeneration; and ingredients that activate the markers of rejuvenation, based on epigenetics. Additionally, it contains exosomes, extracellular vesicles responsible for cell-cell communication that will improve skin regeneration, activation of microcirculation, skin hydration, metabolic stimulation, reinforcement of the skin barrier and help inflammation.

The method consists of different sessions of professional treatment in the clinic, accompanied by a home regimen. The clinic protocol consists of an initial skin preparation in which the skin is cleansed, and make-up will be removed. Then the **skinretin aqueous** (aqueous phase) and **skinretin oily** (oily phase) solutions are applied. To do this, 1 ml of skinretin aqueous phase is removed and mixed with a spatula with 1 ml of skinretin oily in a bowl. It is applied to the face using gloves and a facial massage with whirling techniques until it has been absorbed. Afterwards, to enhance the effect of the treatment, a mask can be applied, followed by a photoprotective cream to finish.

Five sessions are recommended to maximise the therapeutic response, with a frequency of one session per week and can be used alone or in combination with medical-aesthetic equipment such as radiofrequency, other topical treatments such as peeling or microneedling.

I DECLARE that the following points have been explained to me:

- Treatment is **contraindicated** in the following situations:
  - Pregnant or breastfeeding women.
  - Individuals with confirmed hypersensitivity to any of the components of the different products.
  - Individuals with confirmed tendency to develop hypertrophic or keloid scars.
  - Individuals with recent dermatologic surgery in the area to be treated.
  - Individuals with history of skin hypopigmentation, including vitiligo.
  - Individuals with open or semi-open wounds in the area to be treated.
  - Individuals with autoimmune diseases, chronic decompensated diseases and/or active dermatological diseases in the area to be treated.
  - Individuals with active bacterial, viral and/or fungal infections in the area to be treated.
  - Individuals with acne and/or other active inflammatory diseases in the area to be treated.
  - Individuals with coagulation disorders.
  - Individuals with an unstable psychological profile.

- The professional has considered that the indicated treatment is the most appropriate, although there may be other alternatives that would be indicated in other cases and that I have had the opportunity to discuss with the professional. Considering the pros and cons of each of them, I have chosen the intervention described above.
- The number of sessions and/or amount of product that I have been informed that is necessary to achieve the desired effect is indicative, being impossible to know beforehand the exact amount of product or number of sessions that are necessary, due to the different way of absorption/reaction of each patient.
- The professional has explained to me that in order to obtain the expected results it is advisable to strictly follow up the treatment both in the clinic and at home, and that in exceptional cases the treatment regimen should be adapted according to the evolution of the treatment.
- In the case that the treatment is combined with peeling, during 4 weeks prior to the treatment, I must no undergo any other professional peeling procedure (dermabrasion, microdermabrasion, ultrasonic peeling, etc.). Five days before the treatment, it is not recommended to use abrasive or irritating substances; nor to dye, bleach, wax or shave the areas to be treated.
- In the 48 hours following the treatment session, direct and excessive exposure to natural or artificial light, heat sources and saunas should be avoided. Hair removal and laser treatments should also be avoided for a minimum of 15 days.
    - If the treatment is vehiculated with microneedling, cosmetic products and make-up should be avoided on the treated area until at least 2 hours after treatment.
- During the treatment cycle, daily use of very high photoprotection is essential. It is recommended to reapply every 2-3 hours during daytime hours. Maintain this applications pattern as a regular photoprotection practice after the end of the treatment.
- Despite the proper choice of the technique and its correct performance, there may be **RISKS AND COMPLICATIONS** that medical science describes as inherent to this treatment and that may arise immediately or after some time. Among other major risks that have been explained to me are the following:
    - Risks and complications common to any aesthetic treatment, including allergic reactions to the substance used, which remit under appropriate treatment.
    - Risks and complications specific to this treatment that have been explained to me and that I assume and accept: erythema, tingling sensation and/or heat in the area of application, mild inflammation.
- In addition, I have been informed that it is important to inform about my personal history of drug allergies, current medications, pregnancy or breastfeeding, history of facial herpes simplex, personal or family history of keloids or any other circumstances, as there may appear or exists post-treatment risks or complications due to my personal circumstances, previous stat of health, age profession, etc. Other risks or complications that may appear considering my personal circumstances, previous state of health, age or profession are: _____

I ACKNOWLEDGE that the objective of the treatment is to enhance my appearance, with the understanding that some imperfections may persist, and the outcome may not align with my expectations. In this regard, I am informed that the aesthetic results of the treatment are influenced by factors such as the speed of metabolization of the hyaluronic acid. I comprehend that medicine is not an exact science and that no one can guarantee perfection or absolute certainty regarding the results of the treatment. I understand that the result may not be what I expected, and I acknowledge that no such guarantee has been given to me at all.

I RECOGNIZE that during treatment, unforeseen conditions may arise that could necessitate a modification of the initially planned course of treatment. In the event of complications arising during treatment, I authorize the center to seek the necessary assistance from additional specialists, in accordance with its professional judgement.

I UNDERTAKE to diligently adhere to the professional's instructions before, during, and after the treatment, and I accept full responsibility for following the post-treatment measures recommended by the reference center.

I CONFIRM that I have not omitted or altered any information when stating my clinical-surgical history and background, especially those referring to allergies and personal diseases or risks.

I AUTHORISE the taking of photographs of the treated area, which may be utilized for scientific, educational, or medical purposes. I understand that the use of these photographs will not constitute a violation of the privacy or confidentiality to which I am entitled.

I HEREBY CONFIRM that I have comprehended the explanations provided to me in clear and straightforward language. The attending professional has afforded me the opportunity to voice all observations and has thoroughly addressed all questions and concerns I have raised. I have been duly informed, have understood, and accept the scope, risks, and contraindications outlined for the treatment. Furthermore, I confirm that I have fully understood this CONSENT DOCUMENT and agree with each of its provisions. I have also been informed of my right to decline treatment or revoke this consent at any time.

Under these conditions, I _____(patient name) **CONSENT**_____ (practitioners name), to conduct the treatment known as **SKINRETIN XPERT®** by mesoestetic on me, as well as make any modifications and take any measures deemed appropriate during the treatment.

Clinic Name _____Date _____.

Signed: The Patient

Signed: The Professional