

INFORMED CONSENT**DERMAMELAN® INTIMATE DEPIGMENTING TREATMENT**

I, _____ with date of birth ____/____/____, and address _____

With consent, I am happy to undergo the mesoestetic® **DERMAMELAN® INTIMATE** treatment.

BRIEF DESCRIPTION OF THE TREATMENT

dermamelan® intimate is a depigmenting method, especially indicated to achieve the unification of skin tone and the attenuation of pigmentary imperfections of melanic origin located in the external intimate area, groin area and inner thighs. The treatment combines different active ingredients that produce an apparent exfoliation or not and act on the different stages of melanogenesis with the aim of adding effects and achieving a synergy in the attenuation of pigmentary imperfections of the skin, and improves the quality, turgor and appearance of the intimate area.

The dermamelan® method consists of two phases:

- **In-clinic treatment:** a single in-clinic session in which the professional applies an exfoliating solution, followed by an intensive depigmenting mask that seals with an occlusive and protective film. The client then returns home and leaves it to act for the time indicated by the professional. After this time, the film and the mask are removed with plenty of cold water. To restore comfort to the skin, it is recommended to use a soothing mask for 10-15 minutes.
- **Home treatment:** 48 hours after completion of the consultation protocol, the patient will begin to apply the depigmentation treatment at home for 45-90 days, according to medical criteria.

CONTRAINDICATIONS

- Pregnant or breastfeeding women.
- Individuals with hypersensitivity to any of the components of the different products included in the dermamelan® intimate method.
- Individuals with ongoing autoimmune, chronic, decompensated and/or dermatological diseases in the area to be treated.
- Individuals with history of cutaneous hypopigmentation, including vitiligo.
- Individuals with open or semi-open wounds in the area to be treated.
- Individuals with active bacterial, viral and/or fungal infections in the area to be treated.
- Individuals with recent dermatological or gynecological surgery in the area to be treated.
- Individuals recently treated with lasers/EBDs that cause irritation or sensitization of the area to be treated.
- Individuals with unstable psychological profile.

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

- The professional has considered that the indicated treatment is the most appropriate, although there may be other alternatives that would be indicated in another case and that I have had the opportunity to discuss with the professional. Regarding the mentioned treatment, a professional has explained to

me in-depth and in words understandable to me the typical risks it has, the unwanted effects, the risks characteristic to my person, as well as the discomfort or, sometimes, pain that I can feel having a normal postoperative period. Taking into account 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 absorption/reaction of each patient.
- In the 5 days prior to the treatment, it is not recommended to use abrasive or irritating substances. In the 48 hours following the treatment session, the treated area should not be exposed directly and excessively to natural or artificial light, heat sources, saunas or swimming pools. Waxing, electroepilation or photoepilation, as well as other treatments with abrasive or irritating substances are contraindicated for the duration of the treatment.
- It is of the utmost importance to utilize an extremely high level of photoprotection in the event that the treated area is exposed to the sun during the course of treatment. It is recommended that the product be reapplied every two to three hours during daylight hours. It is important to maintain this application pattern as a regular photoprotection practice after the end of treatment.
- Despite the proper choice of technique and its correct administration, the **RISKS AND COMPLICATIONS** that the medical science describes as inherent to this treatment may occur. Among other major risks that have been explained to me are the following:
 - Risks and complications common to any aesthetic treatment, among others: allergic reactions to the substance used (generally mild, which remit under adequate treatment or even without treatment).
 - Risks and complications specific to this treatment that have been explained to me and that I assume and accept: local skin reactions such as burning, stinging, itching, transient erythema, prolonged erythema (more than 72 hours), edema, desquamation, textural changes, hyper- or hypopigmentation in the treated area.
- Furthermore, 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. Post-treatment risks or complications may arise or exist due to my personal circumstances, previous health status, age, profession, etc. Other risks or complications that may appear considering my personal circumstances, previous health status, 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. I am informed that the aesthetic results of the treatment are influenced by factors such as hormonal or vascular changes, genetic predisposition to hyperpigmentation, prior depigmentation treatments, accumulated sun exposure, depilation techniques, mechanical friction, the use of tight clothing and the presence of concomitant conditions (e.g., food intolerances). I recognize that absolute perfection or safety cannot be guaranteed in aesthetic treatments. I understand that the results may not meet my expectations and acknowledge that no such guarantees have been provided.

I RECOGNIZE that during the course of 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 authorise the clinic to seek the necessary assistance from additional specialists, in accordance with its professional judgment.

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 clinic.

I ACKNOWLEDGE that I have fully disclosed all relevant information in my medical and surgical history, with particular attention to allergies, personal illnesses, and any associated risks, without omission or alteration.

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 **DERMAMELAN®**
INTIMATE 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