PRICING GUIDE

TREATMENT AREA

Treatment Area	Price
TRAGUS	$500 - $800
LIP/ MOUTH AREA	$750 - $1,000
JAW AREA.	$800 - $1,250
FOREHEAD	$1,000 - $1,300
CROWS FEET	$1,000 - $1,300
BROW AREA	$1,000 - $1,300
UPPER / LOWER EYE	$1,600 - $2,000
DECOLLETE	$2,250 - $2,500
NECK	$2,000 - $2,500
LOWER FACE & NECK	$3,000 - $3,500
FULL EYES, FACE & NECK	$4,000 - $5,000

GENERAL TREATMENTS — RANGES FROM $650-$4,000

- ACNE SCARS
- GENERAL BODY
- SKIN BLEMISHES
- GENERAL SCARS

CONSULTATIONS ARE NECESSARY FOR ACCURATE PRICING BASED ON SIZE OF TREATMENT AREA & DESIRED OUTCOME.

PRICING SUBJECT TO MARKET DEMAND & COMPETITION AS WELL AS INDIVIDUAL PATIENT'S DESIRED OUTCOME

TREATMENT RECORD

Patient Name:____ DOB:_________________ Date:__________

Treatment #:__________Chief Complaint:______________________________________Consent Signed: Yes No

Photographs Taken: Yes No Technician Name:____

Treatment Area(s)	Technique Used (Dot Matrix, Plasma Abrasion, Plasma Shower)	Skin Reaction, Immediate Post	Chief Concern / Notes
Upper Eyelid Area			
Lower Eyelid Area			
Crows Feet			
Glabella / Forehead			
Perioral (around the mouth) and Mouth Corners			
Nasolabial Folds			
Marionette Area			
Jawline			
Tragus Area			
Lower Neck			
Body Work:_____________			
Décolletage			
Acne Scar Revision			
Scar Revision			

Visual Clinical End Point:____

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Clinician/Physician Signature Date Signed

Aftercare Instructions

To reduce the risk of unwanted side effects, it is imperative that these Aftercare Instructions are followed implicitly.

1. Optimal results are only achieved by maintaining an undisturbed and DRY environment.

2. DO NOT over cool. Cooling stops the tightening effect and could damage the tissue.

3. Immediately after the treatment the skin was treated with the Subnovii Recovery Cream and the Recovery Powder.

   Subnovii Aftercare Cream must be used for several days to ensure optimal healing and results.

   (DO NOT use Bepanthenol/Bepanthen or anything similar - it is too fatty and prevents healing)

4. Each morning and evening (while the scabs are present) apply a VERY THIN layer of the Subnovii Aftercare Cream. Pat the cream on with clean fingers and do NOT rub in or use a sponge.

   Repeat this process if you feel that the skin requires moisturizing during the course of the day and again in the evening.

   Subnovii Downtime Reducer Powder should be used on top of the cream to absorb any excess moisture and keep the scabs dry.

5. To treat temporary pain, 500mg Acetaminophen may be taken. Aspirin MUST NOT be taken, as this can cause more swelling. DO NOT take Ibuprofen or any other anti-inflammatory medication.

6. 'Arnica 6c' pillules can be used to treat swelling. 5 capsules to be taken every hour if necessary until the swelling subsides.

7. As long as the scabs are present avoid the sun, sweating, sauna and steam rooms.

8. DO NOT intentionally remove the scabs. Every manipulation of the scabs can cause an adverse effect. They will fall off on their own within 3 to 7 days. This may take longer for smokers or those taking medication.

9. While the scabs are present they should be kept dry. Should the scabs become wet, do not rub. Use a hairdryer on the area until the crusts are dry. Apply Subnovii Aftercare Cream and Subnovii Downtime Reducer Powder directly afterwards.

10. The skin beneath the scabs is sensitive. The pinkish coloration may last up to 6 months.

11. When the scabs have fallen off, use a sunscreen with SPF 50 on the treated areas. Avoid extreme sun exposure for 3 months and UV rays and extreme low temperatures for 2 weeks. If the above instructions are not followed, pigment deviations and dark spots may occur.

12. Please note: depending on the desired results, more than one treatment may be necessary. Follow-up treatments may only be performed 12 - 16 weeks after the previous treatment as the collagen fibres are still contracting and the skin is very sensitive.

MEDIA RELEASE FORM

I, ________________________, grant permission to **[Practice Name]** to use my image (photographs and/or video) for use in Media publications including:

- Videos
- Email Blasts
- Social Media
- Newsletters
- Website
- In-Office Materials

I hereby waive any right to inspect or approve the finished photographs or electronic matter that may be used in conjunction with them now or in the future, whether that use is known to me or unknown, and I waive any right to royalties or other compensation arising from or related to the use of the image.

Date: ________________________

Signature: ____

Name (please print): ____

Practice Contact:____

Created: October 2020

Client Evaluation and Release

ALL INFORMATION WILL BE TREATED CONFIDENTIALLY

*(NOTE: THIS PATIENT INFORMED CONSENT TEMPLATE IS PROVIDED "AS IS" AND IS INTENDED FOR INFORMATIONAL PURPOSES ONLY. THIS TEMPLATE MAY NOT MEET ALL STATE AND FEDERAL LEGAL OR REGULATORY REQUIREMENTS FOR USE WITH PATIENTS. PHYSICIANS USING THIS TEMPLATE ARE RESPONSIBLE FOR ENSURING THE INFORMED CONSENT FORM USED WITH PATIENTS MEETS ALL APPLICABLE STATE AND FEDERAL LEGAL AND REGULATORY REQUIREMENTS, AND ARE ENCOURAGED TO CONSULT WITH THEIR ATTORNEY.)

____
Full Name

____
Street address

____
Area / Postal Code

____
Date of Birth

____
Mobile Number

____
Email Address

Treatment Area

The customer agrees herewith that the following areas may be treated on their person:

Peri-oral Area ☐ ______________________________

Scar Revision / Acne Scars ☐ ______________________________

Small Targeted Area of Concern ☐ ______________________________

Eyes / Forehead / Glabella Area ☐ ______________________________

Other (Body) ☐ ______________________________

Risk Factors – Treatment may be possible after further clarification.			
Have you had any filler injections within the last 2 months?	Yes/**No**	Have you had sun exposure or been on a tanning bed within the last 4 weeks?	Yes/**No**
Have you had any acid peelings? If so when?	Yes/**No**	Do you suffer with Alcoholism?	Yes/**No**
Have you had a thread lifting or Botox injection? If so when?	Yes/**No**	Do you smoke?	Yes/**No**
Have you had an ablative laser treatment? If so when?	Yes/**No**	Do you suffer from Herpes Simplex (Cold Sores)?	Yes/**No**
Have you experienced problems with numbing injections e.g. at the Dentist?	Yes/**No**	In the last 24 hours, have you taken drugs, aspirin or drank alcohol?	Yes/**No**
Do you suffer from Haemophilia? (bleeding disorder)	Yes/**No**	Do you take blood thinning medication?	Yes/**No**
In the last 14 days have you been treated by a doctor?	Yes/**No**	Do you regularly take St John's Wort, pineapple or kiwi?	Yes/**No**
Are you on regular medication?	Yes/**No**	Do you have any allergies? (incl. heat allergy)	Yes/**No**

ABSOLUTE CONTRAINDICATIONS			
Do you suffer from an auto immune skin condition? e.g. Psoriasis, Eczema.	Yes/**No**	Do you suffer from an Autoimmune disease?	Yes/**No**
Do you take any Anti-acne medication (Roaccutane, Isotretinoin, Vitamin A acid etc.)?	Yes/**No**	Do you suffer from cancer?	Yes/**No**
Radiation/Chemotherapy within last 2 years	Yes/**No**	Do you have a fever / infectious disease?	Yes/**No**
Do you have any metal implants in your body?	Yes/**No**	Do you suffer from Epilepsy?	Yes/**No**
Are you pregnant or breastfeeding?	Yes/**No**	Do you have acute heart disease or blood pressure problems?	Yes/**No**
Regular usage of Cortisone cream or tablets	Yes/**No**	Have you had an operation within the last 14 days?	Yes/**No**
Do you suffer from Diabetes?	Yes/**No**	Do you have a pacemaker?	Yes/**No**
Are you HIV-Positive?	Yes/**No**	Do you suffer from Keloid development?	Yes/**No**
Do you suffer from Hepatitis A, B, C, D, E, F?	Yes/**No**	Do you suffer from Glaucoma?	Yes/**No**
Do you suffer from Bone Disease?	Yes/**No**	Are you currently taking antibiotics?	Yes/**No**

Additional agreements

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I hereby give permission for photos and/or videos of my treatment to be made and stored by my Subnovii Practitioner as confidential material. Yes No	I hereby give permission for photos and/or videos of my treatment to be used for marketing purposes Yes No

Treatment Information

The Subnovii Advanced Plasma Technology is a cosmetic device and is not meant for the treatment of disease or medical ailments.

The Subnovii practitioner may not be in a position to make a diagnosis regarding the benignity of a skin mutation. All treatments may only be done after a skin specialist has made an official diagnosis declaring the benignity of said skin concerns. After treatment, there is a minor risk of hypertrophic/atrophic scarring, as well as hyper/hypo-pigmentation (lighter or darker skin coloration.)

Please be aware there is no claim of permanency with Subnovii treatment.

Treatments with the Subnovii may result in certain reactions e.g. redness and swelling. Should these symptoms persist for longer than 10 days, or should other symptoms present, please contact the Subnovii practitioner who treated you or your local doctor.

The number of treatments necessary to obtain the desired result, depends on the type of treatment and the size of area treated. The minimum period between treatments is 12 weeks. Your Subnovii practitioner may extend this period depending on your individual reaction to the treatment and your skin type accordingly.

To reduce the risk of unwanted side effects, it is imperative that the Aftercare Instructions are followed implicitly.

The risk of hyper-pigmentation is very low, but the risk cannot be avoided. This is a normal skin reaction which usually disappears within a few months. This risk is reduced exponentially if you follow the Aftercare Instructions and avoid sun exposure, or use a sun block with the highest SPF before and after treatment.

Following the treatment, please avoid extreme sun exposure for 3 months and UV-light and extreme low temperatures for 2 weeks. Please do not use the sauna, or steam room for 3 days.

In spite of all due care required, injuries can occur during the plasma treatment. In rare situations and despite using the most modern techniques, allergic reactions are possible. The Client is aware of this possibility and takes sole responsibility.

All follow-up treatments may only be performed 12 weeks after the initial treatment. This is due to the healing and tightening process lasting a minimum of 3 months. Further treatments, subject to charge, may be necessary before the desired effect is obtained.

Client Release

I certify that I have answered the medical questionnaire fully and accurately and I ……………………………. having been advised by…………………………………… completely understand all of the above information and the implications of the treatment that I will be receiving, including the listed side-effects. I can confirm that all of my questions were answered fully and understandably and that I have not been misled or badly informed by the above-named practitioner or clinic. I am aware that any falsification of information submitted by myself could be detrimental to my health and the success of my treatment and that the practitioner or clinic will not be held liable. I have been advised that I may experience discomfort during the treatment. I hereby authorise and direct the practitioner and clinic to administer the prescribed process and perform such procedures as may be deemed necessary or advisable. My signature below constitutes my acknowledgement that (1.) I have read, understood and fully agree with the aforementioned and I have received the Subnovii Aftercare information document. (2.) I give consent to the proposed treatment process that has been satisfactorily explained to me and I have all the information I require. (3.) I hereby give my consent and authorization voluntarily and release the establishment and its agents of any claims that I have or may have in the future in connection with the described treatment.

Signed: ………………………………………………. Date: ……………………………………………

Print Name: ……………………………………………

Practitioner: …………………………………………… Business Name : …………………………………………..

Post-Treatment Agreement

CUSTOMER'S ACCEPTANCE OF TREATMENT

I have examined the results of the treatment closely and declare said results to be in proper order and condition.

_____________________ ____

Date Signature Customer

CUSTOMER'S UNDERSTANDING OF THE IMPORTANCE OF AFTERCARE

I have been given and understand, instruction in essential aftercare and have been given Subnovii Aftercare Cream and

Downtime Reducer Powder which I understand must be used as instructed to protect the treated area and aid healing.

______________________ ____

Date Signature Customer