Patient Photo Consent Form

Patient First Name: _____ **Patient Last Name:** _____

Date of Birth: _____ **Patient/Account #:**_____

I,_____, hereby authorize _____(Forthwith referred to in this agreement as **Health Care Provider**) to use my before and after photos, videos, and/or portrait and related textual information such as testimonials, clinical discussions, or treatment information including descriptions with or without my name, or with a fictitious name (my protected health information).

This protected health information is being used or disclosed for the purpose of education, marketing or as (s)he sees fit for the advancement of aesthetic medicine, educational viewing by other aesthetic professionals, and in the promotion of aesthetics medicine. In addition, my Health Care Provider may also share these materials with **LUTRONIC**, the device manufacturer, for reproduction in marketing and for educational purposes to further and promote aesthetic medicine.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Health Care Provider's address at:

Mailing Address:_____

Email Address: _____

At all times the identity of patient is to be held as a priority, eye blocks are used to protect privacy when needed.

By signing below, I am indicating that I have read and understand the "Consent for Photography" form. I am either the patient or have the authority to give consent for the patient. My questions regarding this consent have been answered. I agree:

1. To allow the recording of my image and voice (e.g., photographs, audio, or video).
2. To distribute my image or recording in any medium, be it print or electronic form, which may include the Internet.
3. To grant permission to Health Care Provider and Lutronic to reproduce the images or recording for marketing or educational purposes worldwide.
4. That there is no reimbursement for the right to take, or to use my photograph or video or recording.

Patient Printed Name _____ **Patient Signature** _____ **Date** _____

Physician Printed Name _____ **Physician Signature** _____ **Date** _____

Please email a scanned copy of this form along with images to rdeschamps@lutronic.com

Tips for Picture Taking

The key to great clinical photographs is consistency, meaning every photograph should be taken the same way each time. It is important that before and after photographs clearly show progression for treatment provided. The main goal is to show the best resolution for each individual patient based on diagnosis and treatment plan.

- Have a designated picture taking area
    - Use same camera, settings and lighting
- Have a plain solid color backdrop
- Good and consistent lighting – camera flashes can wash-out and diminish ability to see clinical results
- Same angle and distance to body part
- Similar patient presentation (no make up, hair pulled back, etc)

Turning in Before and After Images

- Submit original photos is high resolution (300 dpi)
- Include condition being treated
- Patient profile (e.g. skin type, hair color and density, age, sex)
- Pretreatment photos with dates
- Number of treatments required to achieve 'after' results
- Treatment protocol used for each session
- Any combination and/or adjunctive therapy should also be noted
- Dates of treatments and treatment number with each photo
- Length of time between treatments, treatment interval
- Length of follow up post treatment to achieve 'after' results

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