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INFORMED CONSENT FORM FOR LASER THERAPY

I understand that the Lumenis laser is being used for the treatment of _____ under the direction of _____. Although laser therapy is safe and effective in the majority of cases, unexpected adverse events may occur. Unexpected side effects may result from the use of the laser, and the expected response of the treated area may not be achieved.

_____ 1. **Short term effects:** I understand that there are multiple short term effects that may occur with laser therapy, including reddening, irritated raised rash, mild burning, swelling, bruising, numbing, temporary pigmentary change, blistering, scabbing, crusting, flaking, and sensitivity to the sun. Although these effects typically resolve within several days, they may persist for several weeks and rarely, even longer. I understand that the degree of the side effects varies from person to person, and it may not be possible to predict how I will respond.

_____ 2. **Possible permanent effects:** I understand that although most side effects are short term and resolve fairly quickly, some effects may be permanent. Scarring and changes in pigmentation (lighter skin or darker skin) may be permanent.

_____ 3. **Discomfort associated with procedure:** I understand that the laser functions by heating up its target (blood vessels, pigmentation). This heating sensation is minimized by the use of the cooling air, but some level of discomfort may be felt. The level of discomfort depends on the treatment being done, and varies from person to person. The stinging or sensation of heat is typically short term but may persist for several hours after the procedure.

_____ 4. **Effects of UV:** I understand that sun exposure, tanning beds, sunless tanning lotions, and tanning creams can cause discoloration or reaction to laser treatment during and after the procedure. Having any kind of tan prior to therapy or soon after therapy results in an increased chance of blistering, permanent or temporary discoloration, scarring, and discomfort. I understand that avoidance of any UV exposure 1 month prior and 2 weeks after treatment reduces the risk of these effects.

_____ 5. **People excluded from therapy:** I understand that certain patients should not have laser treatment. This includes any patients who have open wounds, malignant skin tumors, patients who have certain disease that make them sensitive to light, patients currently on Accutane or who have been on Accutane within in the last 3 months, and in many cases, patients who have tattoos in the area to be treated.

_____ 6. **Need for multiple treatments:** I understand that many conditions being treated by the laser will require multiple treatments to obtain the desired results. For laser hair removal, the procedure works by targeting growing hair follicles, not dormant hair. Complete destruction of all hair follicles with a single treatment is therefore not possible, and multiple treatments are necessary. For redness/rosacea, results are seen after the first treatment, but multiple treatments are often necessary to remove the desired amount of redness/blood vessels, and multiple treatments are often necessary to smooth a blotchy appearance that may be present after 1 treatment. Everyone responds in different ways and different rates to the treatment.

_____ 7. **Tattoo/permanent makeup:** If there are any tattoos or permanent makeup in the area, there is a possibility of blistering and lightening of the tattoo/makeup.

_____ 8. **Photographs:** I understand that the physician may choose to take photos of my treatment area for the purpose of monitoring my progress.

_____ 9. **For laser hair removal:** I understand that there are other options for laser hair removal such as electrolysis, waxing, and chemical preparations. I understand the difference between these options and laser hair removal, and I am choosing laser as a noninvasive treatment for my hair epilation. I also understand that the hair follicles that are treated are permanently destroyed, and may not grow back (this is especially important when treating certain areas such as the neck, beard/moustache area, scalp). Use of the laser is FDA cleared for permanent hair reduction, and it is possible that new hairs will grow at some point in the treated areas. Response to treatment varies from patient to patient.

_____ 10. **For laser vein treatment:** I understand that this procedure involves a laser to coagulate the vessels and a bruising effect could last up to 6 months. It is possible the results will be minimal or not help at all. I realize that each individual's treatment response is different; therefore it could require multiple treatments to achieve desired results. Other options are available, and may include sclerotherapy and surgery.

_____ 11. **For non-ablative Photofacial:** I understand that erythema (redness) is a common immediate reaction from the **Photofacial** treatment process. This typically resolves in 2 hours, but may last longer. I understand that 4-6 treatments are required for the non-ablative **Photofacial** to be most effective, and it is important to follow the

recommended maintenance schedule for future treatments to keep the best possible results. I also realize that each individual's treatment response may be different, and the number of treatments may vary to achieve desired results.

_____ 12. **For laser treatment of redness/rosacea:** I understand that this procedure for reduction or elimination of redness/telangectasia/rosacea could result in a bruising effect that could last 2-3 weeks. It is possible that the results will be minimal or not help at all. Each individual's treatment response is different; therefore it could require multiple treatments to achieve the desired results.

_____ 13. I understand that my insurance company will not cover the cost of laser therapy, and I am responsible for the complete cost of the service. Payment is due at the time of the treatment. I also understand that once I have started my treatment program, there are no refunds.

_____ 14. I have received, read and understand the post-treatment instructions.

Dr. Petitt has explained the nature and purpose of the laser treatment, including any risks and possible complications, and has discussed the contents of this form with me. I have read and understand this consent form, and I agree to its terms and authorize treatment. I further understand that Dr. Petitt cannot guarantee the results. I will not hold Dr. Petitt orher employees responsible for my individual results.

Patient name (printed)
_____

Patient Signature: _____

(Parent or guardian if patient is under 18)

Date: _____

Physician signature _____

Witness signature _____