PATIENT CONSENT FORM

FOR LASER GENESIS SKIN THERAPY

I herby authorize _____, to perform Laser Genesis Non-Ablative Skin Therapy on me. I understand that this procedure works on promoting vibrant and healthy looking skin by creating a thermal response in the dermis that stimulates new collagen. I understand that multiple treatments are required and it is possible that result will be minimal or not help at all.

I am aware of the following possible experiences/risks:

- DISCOMFORT– Some discomfort may be experienced during treatment.
- REDNESS/SWELLING/BRUISING – Short term redness (erythema) is common and swelling (edema) of the treated area may occur. Additionally, there may be some bruising.
- PIGMENTED CHANGES (Skin Color) – During the healing process, there is a slight possibility that the treated area can become either lighter (hypo-pigmentation) or darker (hyper-pigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- WOUNDS – Treatment can result in burning, blistering or bleeding of the treated areas. If any of these occur, please call the office.
- INFECTION – Infection is a rare possibility whenever the skin surface is disrupted, though proper wound care should prevent this. If signs of an infection develop, such as pain, heat or surrounding redness, please call the office at (949)916-7166.
- SCARRING – Scarring is a rare occurrence, but it is possibility if the skin's surface is disrupted. To minimize the changes of scarring, it is IMPORTANT that you follow all post-treatment instructions carefully.
- EYE EXPOSURE – Protective eyewear (shields) will be provided. It is important to keep these shields on at all times during the treatment in order to protect your eyes from any injuries.

I acknowledge the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that procedure may not work for me.
- Alternative treatments such as topical, microdermabrasion, or surgery.
- Reasonably anticipated health consequences if the procedure is not performed.
- Possible complications/risks involved with the proposed procedure and subsequent healing period.

For women of childbearing age. By signing below I indicate that I am not pregnant. Furthermore, I agree the staff informed should I become pregnant in the course of treatment.

Photographic documentations will be taken.

ACKNOWLEGMENT

BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTANT THE CONTENTS OF THIS PERMISSION FORM FOR TREATMENT FOR VASCULAR LESIONS AND THAT DISCLOSUTRS REFFERD TO HEREIN WERE MADE TO ME.

_____ _____ _____

Signature-Patient or Guardian **Print Name/Relationship** **Date**

Signature-Witness	**Print Name**	**Date**