Consent Form for Erbium Lasers

I_____, consent to and authorize _____

to perform treatments for the following condition(s):_____

Lasers can be used effectively to destroy targets located in the skin with minimal damage to the surrounding tissues. Erbium lasers are used to lighten, fade or remove photo-damaged skin. Visible signs of photo damage include Rhytids (wrinkling), enlarged pores, course skin texture, and pigment alterations.

Despite Erbium lasers high levels of efficacy and safety, they are not free of side effects.

Risks include:

- **Discomfort:** Temporary discomfort during treatment may be experienced

- **Bruising Swelling and Infection:** The skin at or near the treatment site may become fragile. If this happens, Makeup should be avoided and the area should not be rubbed, as this might tear the skin. A blue purple bruise may appear on the treated area, which might last from five to fifteen days. As the bruise fades, there may be rust-brown discoloration of the skin, which fades in one to three months or longer.

- **Erythema:** Redness and edema (swelling) of the treated area can occur but usually subsides within a few hours but can last up to seven days or longer. Irritation, itching, and/or a mild burning sensation or pain similar to sunburn may occur within 48 hours of treatment.

- **Pigment Changes:** Pigmentary changes such as hyper pigmentation and hypo-pigmentation of the skin in the treated areas can occasionally occur. Mostly it is transient, lasting up to six months, but in rare cases it can be permanent. Most cases of hypo- or hyper-pigmentation occur in people with darker skin or when the treated area has been exposed to sunlight before or after treatment. Occasionally these pigmentary changes occur despite appropriate protection from the sun.

- **Scarring:** Scarring which can be hypertrophic or even keloid, can occur.

- **Other known complications of this procedure include:** blisters, reddening; pinpoint pitted bleeding, bruising, superficial crusting, burns, pain, and infections. These side effects are usually temporary, lasting from five to ten days but can be permanent as well.

- **Eye Exposure:** Protective eyewear will be provided. It is important to keep goggles on at all times during the procedure to prevent permanent damage to the eyes.

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Consent:

Even though appropriate measures are taken to reduce side effects, they cannot be completely eliminated in every case. I understand that the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks, there may be other treatments options, such as injections, other types of lasers/light sources or peels. With this in mind, I am choosing this invasive treatment for Rhytids, photodamged skin and other indicated skin conditions.

I have read and understand the Pre-Post treatment instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre and post procedure guidelines are crucial for healing, prevention of scarring, and other side effects and complications such as hyper-pigmentation, hypo-pigmentation, and other skin textural changes.

I have reviewed the list of photosensitizing medications (ones that are more sensitive to sun exposure and burning) and I am ____ or I am NOT ___ (check one) taking any of these medications.

I understand that this examination is not meant to replace the necessity for a complete dermatological examination.

Photographs: I give _____. permission for my photographs to be used to help document my treatment course and possibly used for educational material. Otherwise they will maintain confidentiality.

No guarantee, warranty, or assurance as been made to me as to the results that may be obtained. I am aware that follow-up treatments may be necessary for desired results. Most patients require a number of treatments over several months with gradual results occurring over this time. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative treatments and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

I release the facility, and staff and specific technicians from any and all liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

Client:
Print Name: _____ Signature_____ Date: _____

Witnessed by : _____ Date: _____