Pigment and/or Vascular Photorejuvenation Treatment Consent & Disclosure Form

I, _____ hereby duly authorize _____, physician, healthcare professional, or surgeon in charge, together with trained technicians or such assistants as he/she may designate to perform the procedures using phot rejuvenation treatment (s) on me for the treatment of but not limited to the following skin conditions: Rosacea, Poikiloderma, Telangectasias (spider veins), Sun Damage, Age & Liver Spots, Freckles, Melasma and Rhytides (fine lines and wrinkles). This office will be treating your pigmented and/or vascular lesions using light-based therapy. With this light-based therapy, the pigmented and/or vascular lesions will flake off or fade within 3 weeks after treatment. The pigmented and/or vascular lesions will darken after treatment prior to fading, and a possible sun-burn like irritation may occur, but usually subsides within 12-24 hours. I understand that results vary from patient to patient, depending upon skin color and severity of condition being treated. There is a small possibility this procedure will NOT remove all of the pigmented and/or vascular lesions on my skin even after multiple treatments, and this treatment will NOT prevent future signs of sun damage to my skin. I understand that clinical results may vary based on the individual factors previously listed. I have also completed a medical history, a skin type analysis and a client compliance with pre/post treatment instructions sheet. **I also understand that in order for the procedure to be effective, the following guidelines must be met: 1)** Multiple consecutive treatments will be performed until the desired level of pigment and/or vascularity removal is observed. With the application of light-based therapy, at least two to four treatments are required and sunblock SPF 30 must be worn for at least three weeks after such application/treatment. Sun exposure two weeks prior to and/or after such application/treatment can possibly cause darkening or lightening side effects of the skin; **2)** Avoid sun exposure and use sunblock SPF 30 between treatments; **3)** Avoid eye exposure – protective eyewear (goggles or eye shields) may be provided, and it is important that you keep them on with your eyes closed at all times during the treatment in order to protect your eyes from accidental exposure.

THE FOLLOWING ARE SIDE EFFECTS or COMPLICATIONS which may occur: 1) Discomfort during the treatment; **2)** Slight or temporary redness and irritation may also be experienced on the skin after treatment; **3)** Swelling or minor blistering may occur; **4)** There is a small risk (in some rare cases) of side effects that may include, but are not limited to, lightening or darkening of the skin and/or skin irregularities (changes in skin texture and pigmentation, which is usually temporary). **I understand that if ANY of the following conditions are present, I should NOT be treated:** Under the age of 18 without adult consent, pregnancy, tanning within the last 30 days, inflammatory skin conditions, use of isotrentinoin (Accutane) within 6 months, use of medications causing photosensitivity within the past 4 weeks, Epilepsy, history of Herpes (cold sores unless treated with an anti-viral medication prior to treatment with a doctor's consent), steroid use for at least 3 months.

FITZPATRICK SKIN TYPE when exposed to sunlight. (Circle one below)
1) Always burn, never tan, 2) Always burn, sometimes tan, 3) Sometimes burn, sometimes tan,
4) Rarely burn, tan with ease, 5) Moderately pigmented, always tan, 6) Deeply pigmented, never burn.

I understand that other forms of pigmented and vascular lesion removal methods exist. I certify that I have read this informed consent and understand fully the information that is provided in this agreement form. The physician, nurse and/or technician have answered all my questions regarding this procedure. I have received all of the pre-treatment and post-treatment instructions and understand what is involved in taking care of my skin and the possible results. I understand the nature, goals, limitations and possible complications of this procedure. It has been discussed with me the alternative treatments such as lasers and chemical peels, and I have the right to refuse treatment at any time. I understand that time delays or rescheduling do to hardware complications are not in the control of _____ and will not hold _____or its associates liable for any inconvenience. The fee due is at the time of service. I understand there will be a subsequent charge for any further treatments or treatment package arrangements.

Client/Patient's Name (please print): _____ Photographs: I hereby consent to have photographs of me taken by the physician, nurse or technician and to use such photos for monitoring response to therapy/treatment, medical education and documentation of the medical record.

Signed (Client/Patient/Responsible Guardian): _____ Date: _____

Witnesses' signature: _____ Date: _____