PATIENT CONSENT FORM

FOR LASER TREATMENT

PATIENT/CLIENT NAME:

I hereby authorize and direct any associates or assistants of Sandy Martin M.D. to perform laser treatment on me.

The following points have been discussed with me:
•The potential benefits of the proposed procedure.
•The possible alternative procedures.
•The probability of success.
•The reasonably anticipated consequences if the procedure is not performed.
•The most likely possible complications/risks involved with the proposed procedure and subsequent healing period, including, but not limited to, infection, scarring, crusting, re-growth of hair, and/or blistering.
•Post treatment instructions.

I am aware of the following possible experiences/risks with Laser Surgery:
•DISCOMFORT/ITCHING - Some discomfort may be experienced during laser treatment.
•WOUND HEALING - Laser Surgery can result in swelling, blistering, crusting, or flaking of the treated areas, which may require one to three weeks to heal. Once the surface has healed, it may be pink or sensitive to the sun for an additional two to four weeks, or longer in some patients.
•BRUISING/SWELLING/INFECTION - With some lasers, bruising of the treated area may occur. Additionally, there may be some swelling noted. Finally, skin infection is a possibility although rare, whenever a skin procedure is performed.
•PIGMENT CHANGES (Skin Color) - During the healing process, there is a slight possibility that the treated area can become either lighter or darker in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
•SCARRING - Scarring is a rare occurrence, but it is a possibility when 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 accidental laser exposure.
•SUNBURN-like feeling or sensation

I understand that I will have to wear **protective eyeglasses** during the course of the treatment to protect my eyes from the intense laser light.______

I understand there are less common risks and complications that can occur from a laser treatment that can interrupt my daily life, work routine, or social life. These may include but are not limited to: deep burning, blistering, scab formation, heat rash, bruising, scarring, purpura, infection, hypopigmentation (lighter skin), and hyperpigmentation (darker skin). These may, rarely, become permanent. If any of these were to occur, I understand that my physician or his agent is available to see me and provide post-treatment guidelines to speed my recovery time. If hyperpigmentation occurs, a bleaching cream may be prescribed at my expense, to reduce the darker pigmentation. If I choose to consult my own physician or seek any other medical attention, it is at my own expense.

For best results, 1 have been informed that **multiple treatments** will usually be needed.

I understand that I **may not tan during the course of my laser treatments*** because this can cause a number of complications. I understand that I should **avoid direct sun exposure for 2 weeks** after my laser treatment and that this also includes tanning beds. I have been informed to use a sun block with an SPF of 30 or higher on the treated area during the full course of the laser treatments. I understand it is my responsibility to inform my Physicians if my skin is any darker than when treatment first started. I have made my Physician fully aware of any use of tanning beds, sunless tanning products, or unprotected exposure to the sun in the last 14 days.

Antibiotic ointment may be used for a few days after treatment or possibly only aloe vera gel. I understand **post-treatment** care is very important after the treatments and I will adhere to all the instructions give to me. Improper care to the treated area may increase the chance of scarring, skin texture changes, or other permanent complications.

If I have paid for a package price, I understand that th**ere are no refunds on treatments, or on treatments paid in advance:**

I further understand that the quoted price for treatment is the price for each individual treatment or session, unless otherwise specified in writing.

I consent to having photographs taken during the course of my laser treatments to be retained as part of my file for the purpose of documentation and used for medical education and promotion. I understand all photographs are the property of MARTIN DERMATOLOGY and if used for medical education or advertising purposes, my identity will be kept strictly confidential unless I give specific permission.

I confirm that I am not pregnant at this time and I do not have a pacemaker or internal defibrillator. The medical history and other information I have provided is true and complete to the best of my knowledge and I agree to inform MARTIN DERMATOLOGY of any changes.

I will not hold MARTIN DERMATOLOGY, its owners, or its employees responsible for any complication or side effect or negative effect the hair reduction or skin treatment results I may experience. I realize that my skin and hair is an organ unique to me and that therefore results may vary. I further understand that MARTIN DERMATOLOGY nor SANDY MARTIN MD can prescribe an exact number of treatments to satisfy each individual's opinion and that the number of treatments I complete will be at my own discretion.

I understand that there are other options for treatment but I have voluntarily requested laser treatment.

1 am fully aware that my condition is solely a cosmetic concern and that the decision to proceed is based on my expressed desire to do so.

I am aware that MARTIN DERMATOLOGY requires 24 hours notice of a cancellation or of a need to reschedule and that it is my responsibility to provide that notice. I agree to pay a minimum of $75.00, or half of the scheduled treatment cost, if I fail to give the 24 hours notice. If I choose to prepay my treatment session or sessions, I understand that I may forfeit one of my future sessions if I do not provide MARTIN DERMATOLOGY 24 HOURS notice.

I have read and understood all information presented to me before signing this consent. I have had ample opportunity to ask questions regarding laser treatment, side effects, aftercare, and all of my questions have been answered to my satisfaction.

ACKNOWLEDGMENT

I UNDERSTAND AND ACKNOWLEDGE THAT PAYMENTS FOR THE ABOVE PROCEDURE ARE NONREFUNDABLE.

BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS PERMISSION FORM FOR LASER HAIR REMOVAL TREATMENT AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.

SIGNATURE ______________________ **PRINT NAME**________________________

WITNESS _________________________ **DATE** ______________________

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