Photo Facial & Photo Body Consent

I, _____ have read the following informed consent:
(PRINT NAME HERE)

Photo Facial therapy intends to treat benign vascular and non-vascular skin conditions to lighten, fade, improve or remove the unwanted blood vessels, freckles, birthmarks, fine lines, uneven skin coloring, tone or texture. The wavelength, exposure, duration, and energy level are chosen to selectively damage targeted blood vessels with minimum damage to the surrounding tissue. This intense pulsed light energy and laser energy is absorbed by the blood vessels, hair follicles and pigmented lesions. These targets are damaged, absorbed by the body and the lesions are rendered invisible. Heat stimulated in the underlying dermis promotes collagen production that may reduce mild lines and wrinkles.

I, _____ authorize _____
to perform a procedure on myself known as IPL Photo Facial/Photo Body Rejuvenation

Initial

_____ I have notified the treating clinician that my skin reacts in the following way when exposed to the sun, WITHOUT PROTECTION for about one hour (Please Circle):

Always burns, never tans Always burns, sometimes tans

Sometimes burns, sometimes tans Always tans

_____ I consider myself (Please Circle):

Caucasian Asian Hispanic Mediterranean Middle Eastern Black Other _____

_____ I have notified my treating clinician that I have one or more of the following relative contraindications for Photo Facial Therapy (Please Circle):

Diabetes Bleeding Disorder Keloid Scarring Pregnancy

Using Coumadin Lip or Brow Tattoo

_____ I have reviews the list of light sensitizing medications and indicated which of those medications that I am currently taking.

_____ I have never used Accutane, or have discontinued its use for a minimum of six months prior to beginning Photo Facial Therapy.

_____ I have not been exposed to the sun or tanned in a tanning booth for at least four weeks.

_____ I understand that I must avoid sun exposure during my treatment course and it is recommended that I continue avoidance of sun exposure following treatment.

_____ I understand that a Photo Facial is a series of at least 5 treatments at 3-4 week intervals. However, sometimes more than 5 treatments are needed, which may require additional charges.

_____ Photo Facial is generally considered to be a cosmetic procedure and not covered by insurance. Thus, I am responsible for all treatment costs.

_____ There is a rare possibility of side effects such as scarring and permanent discoloration of the skin (either excessive or lightened coloration). Temporary or permanent, partial or complete hair loss (moustache and beard area), short-term effects such as reddening, mild burning, bruising, blistering, or swelling of the skin are possible. These side effects have been fully explained to me. Additionally, there may ne other unseen adverse reactions not mentioned above. As I go through a series of Photo Facial treatments, the results may at first appear in a striped or random pattern, but blend with subsequent treatments.

_____ There may be other treatment options for my condition. These have been explained to me and are also available upon request.

_____ For Photo Facial to be optimally successful, I accept responsibility in complying with the skin care instructions provided and discussed.

_____ Photographs will be taken to monitor Photo Facial results and may or may not be used for publication and or teaching purposes. Should they be used in public, all measures will be taken to guard my identity and maintain confidentiality.
I do _____, do not _____ (please initial) grant permission for use of my photographs.

_____ Clinical results of IPL Photo Facial and Photo Body therapy vary from patient to patient and my treating clinician can make no guarantees regarding treatment outcomes or avoidance of complications.

_____ I have been given a printed copy of my post-treatment instructions and I understand them completely.

I certify that I have read this form, or that it was read to me, and that I fully understand it. I certify that I have had an opportunity to ask questions about my treatment and those questions have been answered to my satisfaction. The marks above and the signature below is mine.

_____ _____

(Signature of Patient) (Date)

_____ _____

Witness (Attending Physician or Designee) (Date)