CONSENT TO LASER/LIGHT ENERGY TREATMENT

NAME _____ **DATE of BIRTH** _____

ADDRESS _____

CELL PHONE _____ **WORK PHONE** _____ **EMAIL** _____

SKIN TYPE: Review the Fitzpatrick Scale skin types below and check the one that best describes your skin. This information will help your technician determine the most appropriate way to approach your treatment(s):

- ☐ I. Very fair skin; blonde or red hair; light colored eyes; freckles common.
- ☐ II. Fair skinned; light hair, light eyes.
- ☐ III. Common skin type; fair; eye and hair color vary.
- ☐ IV. Mediterranean Caucasian skin; medium to heavy pigmentation.
- ☐ V. Mideastern skin; rarely sun sensitive.
- ☐ VI. Black skin; rarely sun sensitive.

Are you of Asian heritage (Class V) and/or have a history of keloid scarring? ☐ Yes ☐ No

TECHNICIAN: Crystal Walker

PROCEDURE(s): _____

BENEFIT INTENDED _____

I elect to receive the laser/light energy system procedure(s) indicated above for the stated benefit intended. I understand that outcomes may vary, including 1) good results in one session; 2) good results but only after additional sessions; 3) no results; and in rare cases 4) adverse results. I understand that other treatments to enhance outcomes may be recommended, including, but not limited to, the application of skin care products.

Pre-Procedure and Aftercare Instructions: I have received, and will strictly adhere to, all pre-procedure and aftercare instructions. I understand that for those with more color in the skin, it is advised to use a lightening agent leading up to the procedure to suppress the melanin in the skin. I understand there may be an extended period of recovery following the procedure(s), and that aftercare compliance is crucial for healing, prevention of scarring, hyper-pigmentation and hypo-pigmentation. I understand that particularly avoiding sun exposure after the procedure is crucial to reduce the risk of color change and will always apply a broad spectrum SPF 25 or higher, as recommended by my technician. I understand that initially, the skin treated may be red and swollen, that fine, thin scabs may form, and that the healing process typically takes anywhere from one to three weeks. However, I am aware that in rare cases, depending on my skin sensitivity and recovery capacity, healing could take as long as three to six months.

Warning: Treatment is not available to clients who are on **ACCUTANE and PHOTOSENSITIZING** medications. In addition, Clients using **ANTICOAGULANTS** must disclose this to the technician, as treatment may need to be modified to mitigate additional risk associated with the use of these drugs. For women of childbearing age: You confirm that you are not pregnant and do not intend to become pregnant during the course of treatment. Furthermore, you must keep your technician informed should you become pregnant during the course of treatment.

Risks of Care: I understand that the following problems may occur with treatment:

1. **Scarring:** This treatment can create a bruising and a moderate burn or blister to the skin. For an effective treatment, the power (joules) needs to be just below the blistering point which means skin will be red. There is a risk of scarring.

2. **Pigmentation:** The treated area may become either lighter (hypo-pigmented) or darker (hyper-pigmented) in color. This is rare and is usually just temporary, however may become permanent.

3. **Infection:** Although infection following this treatment is unusual, bacterial, fungal, and viral infections can occur. Herpes Simplex virus infections around the mouth can occur following a treatment, even if there is no past history of Herpes Simplex virus infections in the mouth area. Clients with a history of Herpes Simplex virus in the treated area are encouraged to seek preventative therapy. Should any type of skin infection occur, additional treatment, including antibiotics, may be necessary.

4. **Bleeding**: Pinpoint bleeding is rare but can occur following some laser treatment procedures. Should bleeding occur, additional treatment might be necessary.

5. **Skin tissue pathology:** Energy directed at skin lesions may potentially vaporize the lesion. Laboratory examination of the tissue specimen may not be possible. Only clearly benign pigmented lesions can be treated. A doctor's clearance should be obtained in the case of this type of treatment.

6. **Allergic reactions:** In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations, have been reported. Systemic reactions (which are more serious) may result from prescription medicines. Allergic reactions may require additional treatment. Due to skin surface disruption, irritation and histamine reactions may also occur resulting in itching, dermatitis, or other forms of sensitivity.

7. **Vision Damage:** I understand that exposure of the eyes to light during the procedure could damage vision. I will keep the proper eye protection on at all times.

I certify that this consent has been fully explained to me, that I have read the above paragraphs, and that I elect to receive the laser/light energy procedure(s) indicated above. I understand the various risks associated with the Procedure(s) and the importance of properly following pre-procedure and aftercare instructions to minimize those risks. I consent to my photograph being taken before and after the procedure(s).

CLIENT / GUARDIAN SIGNATURE: _____ **DATE:** _____

TECHNICIAN SIGNATURE: _____ **DATE:** _____

NOTICE: Occasionally, unforeseen problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.