



Dermatology Surgical & Medical Group

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INITIAL

CONSENT FOR LASER or IPL TREATMENT

- I authorize *Dermatology Surgical Medical Group* to perform Laser or Intense Pulse Light (IPL) treatment on me. I understand that the procedure is purely elective.
- I understand that serious complications are rare, but possible. Common side effects include temporary redness and mild "sunburn" like effects that may last a few hours to 3-4 days or longer. I understand that treatment cannot be accomplished without producing some epidermal damage and that this may take 2-4 weeks to resolve.
- Pigment changes (light or dark spots on the skin) lasting 1-6 months or longer may occur. In addition, freckles may lighten and temporarily or permanently disappear in treated areas. There is the likelihood of coincidental hair removal when treating pigmented/vascular lesions in hair bearing areas.
- Other potential risks include blistering, crusting, itching, pain, bruising, skin whitening, burn, infection, scabbing, scarring, swelling, rash, permanent increase or decrease in pigmentation and failure to achieve the desired result. Laser or Intense light can cause eye injury and to prevent this, protective eyewear must be worn during treatment.
- I understand that sun exposure or use of tanning lamps or self-tanning creams, and not adhering to the post-care instructions provided to me may increase my chance of complications.
- For your comfort numbing cream will be utilized prior to each treatment. Use of numbing cream is contraindicated during pregnancy or if you are nursing, if you have liver disease or if you are allergic to Lidocaine, Tetracaine or PABA.
- I am not pregnant or nursing and will inform the provider if this changes during treatment.
- I am not allergic to Lidocaine, Tetracaine or PABA and will inform the provider if this changes during treatment.
- I have no liver disease and will inform the provider if this changes during treatment.
- During treatment for hair reduction, I understand that since hair follicles generally grow at angles within the skin it is possible to affect follicles that are not directly in the beams apparent path at the skin surface, and for that reason it is not advisable to shape or sculpt precise hair bearing areas such as eyebrows etc.
- I understand that maintenance treatments are often required to maintain optimal results.
- I understand photographs will be taken to evaluate treatment effectiveness.
- I consent to photographs being taken for medical education, training, professional publications or sales purposes. No photographs revealing my identity will be used without my written consent. If my identity is not revealed, these photographs may be used and displayed publicly without my permission.
- Before and after treatment instructions have been discussed with me.
- The procedure as well as potential benefits and risks have been explained to my satisfaction. I have had all my questions answered. I freely consent to the proposed treatment.
- I understand that DSMG cannot guarantee results and that results vary.
- Once treatment has begun, payment is not refundable, or transferable to another site.
- I understand that this is a cosmetic procedure and therefore not covered by my insurance.
- A "no-show" or less than 24 hour cancellation notice for an appointment will have an assessment of \$75 prior to the resumption of the therapy.

Patient Signature: _____ Date: _____

Print Name: _____

Witness Signature: _____ Date: _____

Print Name: _____





Dermatology Surgical & Medical Group

Laser / IPL Consult Medical History Questionnaire

Date: _____

Patient Name: _____ DOB: _____

Photo Consent: _____ Photos Taken: _____

Fitzpatrick rating

(Circle one) I II III IV V VI Heritage: _____

Treatment area hair color: white gray black red brown blonde

General Stature: S M L

Preferred Treatment: Laser Hair Reduction Photo Facial Telangectasia
 Pigmented Lesion Resurfacing

Area to be treated: _____

Tattoos: _____

Last unprotected sun exposure or tanning bed use: _____

Use of sunless tanner: _____

Menstrual Dysfunction: _____

Use of mechanical epilating device _____ Last date: _____

Medications: _____ Allergies: _____

Pregnant Status: _____

History of seizures: _____

History of scars: _____

Active skin infections: _____ Immunesupressed: _____

Herpes simplex virus: _____ Gold Treatment: _____

Trentinoin (Retin-A / Renova): _____ Accutane (Oral Isotrentinoin): _____

Reviewed by: _____ Signature: _____ Date: _____
(Provider Name)

Pre-Treatment Recommendation: _____

Consent Signed: Yes / No Series Cost: _____ # of treatments in series: 4 / 5 / 6

Notes: _____

