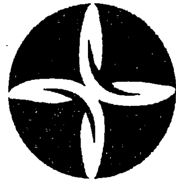

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INITIAL

CONSENT FOR LASER or IPL TREATMENT

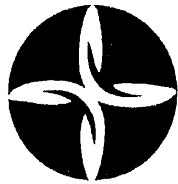
- ______I authorize *Dermatology Surgical Medical Group* to perform Laser or Intense Pulse Light (IPL) treatment on me. I understand that the procedure is purely elective.
- ______I understand that serious complications are rare, but possible. Common side effects include temporary redness and mild "sunburn" 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 your 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 <u>it is not advisable to shape or sculpt precise hair bearing areas such as eyebrows etc.</u>
- ______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: ___________________________ Immunesuppresed: _____________________________

Herpes simplex virus: ___________________________ Gold Treatment: ___________________________

Trentinoin (Retin-A / Renova): _____________________ Accutane (Oral Isotrentinion): ___________________

Reviewed by: ___________________________ Signature: _________________________Date: _____________
(Provider Name)

Pre-Treatment Recommendation: ____

____

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

Notes:____

____

____