

INFORMED CONSENT FOR LASER THERAPY - LIABILITY WAIVER AND RELEASE



In signing this document, I consent to the use of laser therapy in my treatment and acknowledge that I understand the risks associated with the use of lasers. Although laser therapy is safe and effective in almost all cases, unexpected adverse events may occur. Unexpected side effects may result from the use of the laser & the expected response of the treated area may not be achieved.

Short term effects: I understand that there are multiple short-term effects that may occur, including reddening, irritated raised rash, mild burning, swelling, bruising, numbing, temporary pigmentary change, blistering, scabbing, crusting, flaking & sensitivity to the sun. Although these effects typically resolve within several days, they may persist for several weeks and rarely, even longer. I understand that the degree of the side effects varies from person to person, and it may not be possible to predict how I will respond.

Possible permanent effects: I understand that although most side effects are short term and resolve quickly, some effects may be permanent. Scarring, changes in pigmentation & hair loss may be permanent.

Discomfort associated with procedure: I understand that the laser functions by heating up its target (blood vessels, pigmentation). This heating sensation is minimized by moving the laser over the treatment area, but some level of discomfort may be felt. The level of discomfort depends on the treatment being done, and varies from person to person. The stinging or sensation of heat is typically short but may persist for several hours after the procedure.

Effects of UV: I understand that sun exposure, tanning beds, sunless tanning lotions, and tanning creams can cause discoloration or reaction to laser treatment areas during and after the procedure. Having any kind of tan prior to therapy or soon after therapy results in an increased chance of blistering, permanent or temporary discoloration, scarring, and discomfort. I understand that avoidance of any UV exposure 1 month prior and 2 weeks after treatment reduces the risk of these effects.

People excluded from therapy: I understand that certain patients should not have laser treatment. This includes any patients who have open wounds, malignant skin tumors, patients who have certain disease that make them sensitive to light, patients currently on Accutane (Isotretinoin) or who have been on Accutane within in the last 3 months, and in many cases, patients who have tattoos.

Need for multiple treatments: I understand that some conditions being treated by the laser may require multiple treatments to obtain the desired results. Everyone responds in different ways and different rates to the treatment.

Tattoo/permanent makeup: If there are any tattoos or permanent make up in the area, there is a possibility of blistering and lightening of the tattoo/makeup.

Photographs: I understand photos or video of my treatment may be taken. These may be used for teaching health professionals or shown for scientific reasons. I will NOT be identified in any photo or video.

I agree to wear proper eyewear. Eye injury due to use of the laser is a risk to the patient and to the clinician; however, the risks are almost completely eliminated with the use of proper eyewear.

I have informed my practitioner of any health conditions that might be a contraindication. Contraindication including treating over a fetus, a known cancer, the thyroid or a pacemaker. Patients on immune suppression therapy should not have laser therapy as it can boost the immune system.

I understand that this procedure is elective & there are other options for treatment including no treatment.

I understand that my insurance company may not cover the cost of laser therapy, and I am responsible for the complete cost of the service. Payment is due at the time of the treatment unless other arrangements have been made in advance. I also understand that once I have started my treatment program, there are no refunds.

My practitioner or an associate has explained the nature and purpose of the laser treatment, including any risks and possible complications, and has discussed the contents of this form with me. I have read and understand this consent form & I agree to its terms and authorize treatment. I do hereby waive, release, absolve, indemnify and agree to hold harmless the practitioner and his associates for my individual treatment results. I further understand that results CANNOT be guaranteed.

Patient name (printed) _____ Date: _____

Patient Signature: _____

(Parent or guardian if patient is under 18) If signed by other than patient, indicate relationship: _____

Physician/Practitioner signature _____