PATIENT INFORMATION FORMS

Be sure that your patient reads and understands these forms and signs the Consent to Pulsed Light Treatment before administering treatment.

CONSENT TO PULSED LIGHT TREATMENT

I authorize _____to perform pulsed light treatment on me. I understand that this procedure is purely elective.

I understand the following:

- Serious complications are rare but possible.
- Common side effects include temporary redness and mild "sunburn" like effects that may last anywhere from a few hours to several days.
- Treatment of benign pigmented lesions and vascular lesions cannot be accomplished without producing some epidermal damage, and 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 may temporarily or permanently disappear in treated areas.
- There is the likelihood of coincidental hair removal when treating pigmented or vascular lesions or acne in hair-bearing areas.
- Other potential risks include blistering, crusting, itching, pain, bruising, skin whitening, burns, infection, scabbing, scarring, swelling, and failure to achieve the desired result.
- 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.
- I understand the importance of having an accurate diagnosis of pigmented lesions (brown spots on the skin) by a physician prior to treatment, as treatment of an undiagnosed skin cancer may delay proper medical care.

I consent to photographs being taken to evaluate treatment effectiveness, for medical education, training, professional publications or sales purposes. No photographs revealing my identity will be used without my consent. If my identity is not revealed, these photographs may be used and displayed publicly without my permission.

Pre- and post-treatment instructions have been discussed with me. I have read and understand the attached Exclusionary Criteria. This procedure as well as alternative treatment options and the potential benefits and risks of each have been explained to my satisfaction. I have had all my questions answered.

I freely consent to the proposed treatment.

Patient's signature _____Date _____

Print name _____

Parent's signature (if patient is a minor) _____Date _____