
# PATIENT CONSENT FORM

FOR LASER GENESIS SKIN THERAPY

I hereby authorize Dr._____ or any delegated associates to perform Laser Genesis Non-Ablative Skin Therapy on me. I understand that this procedure works on promoting vibrant and healthy looking skin by creating a thermal response in the dermis that stimulates new collagen. I understand that multiple treatments are required and it is possible the result will be minimal or not help at all.

I am aware of the following possible experiences/risks:

- DISCOMFORT – A slight warming sensation may be experienced during treatment.
- REDNESS/SWELLING/BRUISING –Short term redness (erythema) is common and swelling (edema) of the treated area may occur. Additionally, there may be some bruising.
- PIGMENT CHANGES (Skin Color) – During the healing process, there is a slight possibility that the treated area can become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- WOUNDS – Treatment can result in burning, blistering or bleeding of the treated areas. If any of these occur, please call our office.
- INFECTION - Infection is a rare possibility whenever the skin surface is disrupted, though proper wound care should prevent this. If signs of infection develop, such as pain, heat or surrounding redness, please call our office __(Phone number)_____.
- SCARRING – Scarring is a rare occurrence, but it is a possibility if the skin's surface is disrupted. To minimize the chance of scarring, it is IMPORTANT that you follow all post-treatment instructions carefully.
- EYE EXPOSURE – Protective eyewear (shields) will be provided. It is important to keep these shields on at all times during the treatment in order to protect your eyes from injury.

The following points have been discussed with me:

- The potential benefits of the proposed procedure
- The possible alternative procedures such as topicals, microdermabrasion or surgery
- The probability of success
- The reasonably anticipated consequences if the procedure is not performed
- The most likely possible complications/risks involved with the proposed procedure and subsequent healing period

For women of childbearing age. By signing below I indicate that I am not pregnant. Futhermore, I agree to keep Dr._____and staff informed should I become pregnant in the course of treatment.

Photographic documentation will be taken. I hereby do___do not___authorize the use of my photographs for teaching purposes.

**ACKNOWLEDGMENT: BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS PERMISSION FORM FOR LASER GENESIS TREATMENT AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.**

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| **Signature-Patient or Guardian** | **Print Name/Relationship** | **Date** |
| **Signature-Witness** | **Print Name** | **Date** |