826 BUSTLETON PIKE, UNIT 101 A
FEASTERVILLE, PA 19053
215-305-8206

Informed Consent Form for Laser/IPL reatments.

Consent for Laser/IPL Treatment I, _____, understand that the Laser/IPL System is intended for Photorejuvenation, benign vascular and pigmented lesions, and/or permanent hair reduction and that clinical results may vary in different skin types. There are several alternatives to treatment including but not limited to other laser treatments, chemical peels, radiofrequency treatments, or no treatment at all. I understand that the possible risks of the procedure include **pain, bruising, swelling, redness, itching, skin inflammation or irritation (dermatitis), allergic reaction, scarring, blistering, hypopigmentation, hyperpigmentation, mottling of skin vascularity and pigmentation, and other unforeseen complications**. I understand that a single procedure will most likely fail to remove all my unwanted pigment, vascular or pigmented lesions, or hair in the area treated. Multiple treatments are required. Individual response will vary according to skin types, hair color, degree of tanning, follow up care, and the body area being treated. Eye injury is possible but unlikely, providing complete eye protection is properly used throughout laser treatment sessions. I understand the treatment may be painful, but this is typically manageable without any pain medication. **Color changes, such as hyperpigmentation (brown/red discoloration) or hypopigmentation (skin lightening), may occur in treated skin. This may take several months to resolve, if at all.**

Unprotected sun exposure in the weeks following treatments is contraindicated as it may cause or worsen this condition. Blistering of the skin may occur. Scarring is uncommon but may occur. Based on the experience of many other physicians we have found that those people who tend to sunburn rather than tan usually obtain good results on the first and subsequent visits. On the other hand, those who tan more easily tend to have more variation in their results. Some patients in this category will experience partial results and some will experience no improvement at all.

I certify that I do not have any of the following conditions which are **CONTRAINDICATIONS** to laser treatment: **history of melanoma, raised moles, suspicious lesions, keloid scar formation, active infections, open lesions, hives, herpetic lesions, cold sores, tattoos or permanent make-up in area of treatment, recent use of Accutane, tetracycline, or St. John's wort in the last year, autoimmune diseases such as Lupus, Scleroderma, Vitiligo. I certify that I am not**

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pregnant, trying to get pregnant, or nursing. I have informed my physician of my recent sun exposure and if I have had any, I understand the risks of skin discoloration with treatment.

I understand that the treatment by the Laser/IPL system involves payment, and the fee structure has been fully explained to me. With this in mind, I am choosing to try Laser/IPL non-invasive treatment for Photorejuvenation, vascular, pigmented lesions and/or permanent hair reduction.

I give permission for any pictures or videotape taken of me may be used for either teaching or publication, if considered appropriate. I give permission for my pictures to appear in YURAMED photo album for other potential patients to view.

I have been given the opportunity to ask questions about my condition and the treatment, alternative forms of treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I have sufficient information to give this informed consent.

I certify that I have completely read the above form and the form have been fully explained to me, and I understand its contents.

I understand that every effort will be made to provide a positive outcome, but that there are no guarantees. I understand the procedure and risks, and accept the risks, and request that this procedure be performed on me by qualified staff.

Patient Name (print)_____
Patient Signature_____ Date_____
Witness Name (print) _____ Witness Signature_____

Date _____

IPL HAIR REMOVAL POLICY

By signing below I understand that if I am scheduled for any laser or radiofrequency treatment I must make sure the area is cleanly shaved the night before the time of my scheduled appointment.

Signature:_____ **Date:**_____