cosmetic surgery
AFFILIATES
educated • experienced • sincere

LASER SURGERY CONSENT

I understand that the purpose of this procedure (ActiveFX™, MaxFX™, etc) is for: _____

_____

There are several alternatives to treatment including but not limited to other laser treatments, chemical peels, RF treatments, or no treatment at all.

I understand that the possible risks of the procedure include crusting, pain, purpura, swelling, redness, bruising, scarring, blistering, hypopigmentation, hyperpigmentation, mottling of skin vascularity and pigmentation and unforeseen complications. Eye injury is possible but unlikely, providing complete eye protection is properly used throughout laser treatment sessions.

I understand that a single procedure will most likely fail to completely remove all my dyschromia, or textural problems in the area treated. Individual response will vary according to skin types, hair color, degree of tanning, follow up care, and the body area being treated.

I understand the treatment may be painful, but this is typically manageable without any pain relief 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 happens but is uncommon.

I further agree that any pictures or videotape taken of me may be used for either teaching or publication, if considered appropriate, unless I notify the doctor in writing that he or she is not to use these photographs prior to publication.

I understand that the doctor is not an agent of Lumenis Inc., and that Lumenis Inc., is not an agent of the doctor for the purposes of the procedure or treatment. I hereby hold Lumenis Inc. and any of its affiliates, harmless of any errors and omissions of the doctor in connection with the procedure or treatment.

I have been asked at this time whether I have any questions about this procedure and do not. I understand the procedure, and risks, accept the risks, and request that this procedure be performed on me by the doctor or other qualified staff.

Patient's Name (Print): _____

Patient's Signature: _____ Date _____

Witness Name (PLEASE PRINT): _____

Witness Signature: _____ Date _____

Practitioner's Signature: _____ Date _____

YOU WILL SIGN THIS DOCUMENT ELECTRONICALLY WHEN CHECKING IN TO OUR OFFICE ON THE DAY OF YOUR SURGERY.

THERE IS NO NEED TO PRINT THIS DOCUMENT.

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