Name: _____ **Occupation: _____**
Phone Number: _____ **Age: _____**
Email: _____

- Are you pregnant or trying to conceive? **Y/N**
- Are you being treated for any medical conditions? **Y/N**
  If so, please specify: _____
- Do you have any skin allergies? **Y/N**
  If so, please specify: _____

I understand that the Er:YAG laser is being used for the treatment of _____ under the direction of _____. Although the laser therapy is safe and effective in the majority of cases, unexpected adverse events may occur. Unexpected side effects may result from the use of the laser, and 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 with laser therapy, including reddening, irritated raised rash, mild burning, swelling, bruising, numbing, temporary pigmentary change, discharge, blistering, scabbing, crusting, flaking, and 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 fairly quickly, some effects may be permanent. Scarring and changes in pigmentation (lighter skin or darker skin) may be permanent.

Discomfort associated with procedure: I understand that the laser functions by heating up its target. This heating sensation is minimized, 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 term but may persist for several hours after the procedure.

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 the last 3 months, and in many cases, patients who have tattoos in the area to be treated.

Need for multiple treatments: I understand that many conditions being treated by the laser will require multiple treatments to obtain the desired results.

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

I understand that my insurance company will 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. I also understand that once I have started my treatment program, there are no refunds.

I have received, read and understand the post treatment instructions.

The specialist 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, and I agree to its terms and authorize treatment. I further understand that the specialist cannot guarantee the results. I will not hold the specialist of his/her employees responsible for my individual results.

Patient's signature: _____