LASER TREATMENT CONSENT FORM

I _____, hereby authorize and direct Lenox Laser & Esthetics and its physicians, estheticians, employees and associates:

____ to perform Laser Hair removal using the Cool Glide or Pro Wave770. I understand that this procedure works on growing hairs and NOT on dormant hairs. For this reason, destruction of all hair follicles from any one treatment is unlikely, and I understand that I will require several treatments to obtain a significant, long-term reduction of hair growth. I also understand that some people may not experience complete hair loss even with multiple laser procedures.

____ to perform Laser Genesis Non-Ablative Skin Therapy on me. I understand that this procedure works to promote vibrant, healthy looking skin and combat the signs of aging.

____ to perform Limelight IPL skin therapy for the treatment of facial telangiectasia, to diffuse redness and solar lentignes. I understand that continued sun exposure may complicate the procedure and cause skin damage.

____ to perform IPL Photo Skin Therapy for the treatment and reduction of brown pigmentation and sun/ age spots. I understand that continued sun exposure may complicate the procedure and cause skin damage.

____ to perform TITAN Skin Tightening treatment for skin tightening. The TITAN procedure stimulates new collagen growth deep in the skin by thermal heating.

It has been explained to me that a laser treatment is considered a cosmetic procedure, and that I am responsible for all costs associated with each procedure and payment is to be made in full at the time of each treatment.

I agree that the following points have been discussed with me: (1) the potential benefits of the proposed procedure; (2) the possible alternative procedures; (3) the probability of success; (4) the reasonably anticipated consequences if the procedure(s) is not performed; (5) the most likely complications and risks involved with the proposed procedure(s) and subsequent healing period, including but not limited to, infection, crusting, scarring, re-growth of hair, change in skin color and/or blistering and (5) post-treatment instructions.

I am aware of the following possible experiences and risks with laser treatment, including but not limited to:

DISCOMFORT: some discomfort may be experienced during laser treatment

WOUND HEALING: Laser treatment can result in swelling, blistering, crusting, or flaking of the treated areas, which may require one to three weeks to heal. Once the surface has healed, it may be pink or sensitive to the sun for an additional two to four weeks, or longer in some patients. I understand that I should remain out of the sun and use sun block during this healing period.

BRUISING/ SWELLING/ INFECTION: With some laser treatments, bruising of the treated area may occur. Additionally, there may be some swelling noted. Finally, skin infection is a possibility although rare, whenever a laser skin procedure is performed.

PIGMENT (SKIN COLOR) CHANGES: During the healing process, there is possibility that the treated area may become either LIGHTER or DARKER in color compared to the surrounding skin. This is usually temporary, but on rare occasion it may be permanent.

SCARRING: scarring is a rare occurrence, but it is a possibility when the skins surface is disrupted. To minimize the chances of scarring, it is VERY IMPORTANT that I follow all post-treatment instructions. Such post-treatment instructions have been explained to me.

EYE EXPOSURE: protective eyewear (shields) will be provided during the treatment. It is important to keep these shields on at all times during the treatment in order to protect my eyes from accidental laser exposure.

I understand that any procedure performed by the Cutera Laser is inappropriate for individuals who (1) are pregnant; (2) are prone to keloid formation; (3) have a history of poor wound healing; (4) are taking medication which creates light sensitivity; (5) are taking anti-seizure medication; (6) are hypersensitive to light; (7) have a personal or family history of skin cancer; (8) have undiagnosed lesions; (9) had a recent herpetic outbreak; (10) have unstable diabetes or an auto-immune disorder and (11) have a photosensitive skin disorder.

ACKNOWLEDGEMENT

I UNDERSTAND AND ACKNOLEDGE THAT PAYMENTS FOR THE LASER PRECEDURES ARE NON-REFUNDABLE.

BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS PERMISSION FORM FOR LASER TREATMENT AND THAT DISCLOSURES REFFERED TO HEREIN WERE MADE TO ME. I HEREBY RELEASE LENOX LASER & ESTHETICS FROM ANY AND ALL POTENTIAL CLAIMS, LIABILITIES AND DAMAGES THAT MAY RESULT FROM LASER PROCEDURES.

Patient signature:_____ Date: _____

LASER TREATMENT CONSULTATION

Full Name:_____ Date:_____

Primary skin concerns:_____

Past medical/ surgery history:_____

Current medications:_____

Allergies:_____

Any history of:	Date of last exposure/ medication
Accutane (within last 12 months)	NO YES _____
Antibiotics (within last 7 days)	NO YES _____
Coagulation Problems	NO YES _____
Cold sores/ Herpes on treatment area	NO YES_____
Diabetes	NO YES_____
Gold Therapy	NO YES_____
Skin cancer(s)	NO YES_____
Keloids/excessive scarring	NO YES_____
Pacemaker	NO YES_____
Photosensitive drugs (within last 4 weeks)	NO YES_____
Pregnancy	NO YES_____
Retinoids on treatment area (within last 3 days)	NO YES_____
Eczema	NO YES_____
Epilepsy/ Seizures	NO YES_____

IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS, ACCORDING TO OUR MEDICAL DIRECTOR YOU MUST WAIT UNTIL AFTER THE PRESCRIBED PERIOD (WHERE APPLICABLE) AND/ OR OBTAIN THE APPROVAL OF A PHYSICIAN PRIOR TO TREATMENT.

For our information, we would also like to know if you have had any of the following:

	Date of last exposure/medication
Chemical peels	NO YES_____
Microdermabrasion on treatment area	NO YES_____
Botox/ Restylane on treatment area	NO YES_____
Implants in treatment area	NO YES_____
Perm Lip/ Collagen	NO YES_____
Previous laser treatment	NO YES_____
Suntan/ Self Tanner on treatment area	NO YES_____
Tattoos on treatment area	NO YES_____
Vitiligo	NO YES_____
Waxing on treatment area	NO YES_____

PATIENT HAS RECEIVED VERBAL AND A COPY OF PRE/POST TREATMENT INSTRUCTIONS.ALL BENEFITS, RISKS, PROBABILITY OF SUCCESS AND ALTERNATE PROCEDURES HAVE BEEN REVIEWED.

Patient Signature: _____

Esthetician signature/physician: _____ Date: _____

Patient Laser Treatment Day Acknowledgment

Full Name:_____ Date Of Birth:_____

Circle: **Initial:**

1. I HAVE / HAVE NOT waxed or tweezed within 1 month prior to laser treatment. _____
2. I HAVE / HAVE NOT taken antibiotics within 7 days prior to laser treatment. _____
3. I HAVE / HAVE NOT used self tanners/spray tans within 2 weeks prior to laser treatment. _____
4. I HAVE / HAVE NOT used any RETINOL/ BENZYOL PEROXIDE containing products within 7 days prior to laser treatment. _____
5. I HAVE / HAVE NOT had sun exposure or utilized tanning beds within 2 weeks prior to laser treatment. _____

BY MY SIGNATURE BELOW, I CERTIFY THAT ALL STATEMENTS ABOVE ARE TRUE.

Patient Signature:_____ **Date**:_____

Laser Tech Signature: _____ **Date**: _____