IADVL- ACADEMY- SPECIAL INTEREST GROUP- LASERS AND AESTHETICS

CONSENT FORM FOR LASER FOR PIGMENTED LESIONS

Mr. / Mrs. / Miss____
Age ______________________________
Address ____
____
City________________
Phone No. ______________

Name of PROCEDURE_____________________________

Type of laser to be used: __________

The purpose of this procedure is to reduce and improve ________________in the area indicated above. The procedure requires more than one treatment and the total number of treatments and clinical results may vary between individuals.

No guarantee, warranty, or assurance has been made to me as to the results that may be obtained.

I am also aware that follow-up treatments may be necessary for desired results. Some lesions cannot be removed completely and there is no way one can predict the final outcome and number of sittings.

I was also informed about the other alternative methods as well as their benefits and disadvantages. I understand that for ideal results, this procedure can be combined with chemical peels, microdermabrasion, etc.

I have been told that my skin will not look good for the first few days after the procedure. There will be some pain, swelling, redness, scabbing and crusting which usually recovers by 7 to 15 days.

I am fully aware of the possible side effects and risks involved in this procedure. I am also aware that this particular procedure may not always be successful and no guarantee can be made for successful outcome of such procedure.

The possible risks of the procedure include but are not limited to pain, purpura, swelling, redness, bruising, blistering, crusting/scab formation, infection, and unforeseen complications which can last up to many months, years or permanently.

There is a risk of scarring, textual and/or color changes in the skin, which can be permanent.

Some of the pigmented lesions are sensitive to sunlight and there are chances of recurrence of the lesions even after complete clearance.

Topical, local or general anesthesia is required in few patients. I am ready to take the appropriate form of anesthesia.

I agree that any pictures taken of my treatment site may be used for publication or teaching purposes; however my name or identity will not be disclosed and complete confidentiality will be maintained.

By signing below, I acknowledge that I have read the adverse reactions above and I feel that I have been adequately informed of the risks of Laser treatment.

Before each treatment, I will inform the doctor if I have taken any new medications since my last treatment.

I also agree to comply with the recommended aftercare instructions.

I hereby release Dr. and its designated staff from liability associated with the above procedure.

My questions regarding the procedure have been answered satisfactorily.

I authorize Dr. and his/her designated staff to perform Laser treatment on my body.

The payment and fee structure is informed to me. I am ready to pay per sitting or package basis. [Package if opted for includes minimum number of sittings and I have to pay accordingly if more sittings are required]

SIGNATURE OF PATIENT/THUMB IMPRESSION
SIGNATURE OF PARENTS /GUARDIAN (FOR MINORS) DATE:

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NAME AND RELATIONSHIP IF SIGNED BY OTHER THAN PARENT

WITNESS: DATE:

NAME_______________________________
SIGNATURE____________________

DATE: ________________________

SIGNATURE OF DOCTOR---DATE---------------

TRANSLATED IN PATIENTS LANGUAGE BY---------------------