



ALBUQUERQUE
LASER CENTER

LASER TREATMENT CONSENT

I, _____, authorize the Albuquerque Laser Center to perform
(client name)

the following specific laser treatment(s) for:

- Hair Removal Facial Rejuvenation Removal of Leg (spider) Veins
 Scars (including acne) Removal of Facial Veins Tattoo Removal
 Skin Tightening Removal of Pigmented Lesions
 CO2 / CO2 Lesion Removal

Prior to the laser treatment, I understand that photographs will be taken for the medical record. These photos are for documentation of specific treatment areas and to track the progress of treatment. Patient photos are NEVER released for any purpose without my specific written consent.

For best results, I understand that multiple treatments will be necessary. I have been informed that complete clearing of the hair or skin abnormality may not be possible and will depend upon my skin type, my age and the color of the hair or on the skin abnormality. Lesions most commonly fade slowly over time as normal body processes eliminate these destroyed cells. If I am being treated for hair reduction, I should notice thinner and less hair over a period of time.

I understand that immediately following the laser treatment, redness, swelling, discomfort, bruising, and/or discoloration may develop at the treatment site. I understand that any discoloration may last 7 to 14 days; however, swelling should resolve within several days. Discomfort may be treated with the application of cool compresses or topical soothing agents.

During the laser treatment, I understand that my eyes will be covered with laser specific safety eyewear or an opaque material to protect them from the intense light. I will keep my eyes closed, and I will not attempt to remove the eye protection during the treatment.

My provider and I may elect to use a form of topical anesthesia to reduce discomfort. During the procedure, a cryogen spray, which cools the skin, may be used to decrease the discomfort and to protect the skin. Anesthesia options and risks will be discussed with me in advance.

I will be given complete instructions regarding after-care of the treated area. I agree to follow these instructions carefully to minimize the chance of incomplete healing, skin textural changes, or scarring. Sun avoidance and /or the use of a sun block will be necessary. Tanning will need to be avoided.

Initial _____

I have been informed of the following possible risks and complications of this procedure, which include but are not limited to:

- red-purple discoloration, bruising
- itching (hive-like response which lasts 2-3 hours to 2-3 days)
- herpes simplex virus activation
- burns, blisters, scabbing, crusting, skin color and /or textural changes
- darkening of the skin; transient or long term
- lightening of the skin; transient, long term or possibly permanent
- scarring (rare, possibly permanent)

Please signify your agreement by initialing each statement below.

- _____ I have provided my past and current medical history and medications.
- _____ I consent to the taking of photographs during the course of my laser therapy for healthcare records.
- _____ I consent to using my photographs for medical education and /or marketing purposes. My name will not be used to identify these photographs.
- _____ I am not currently pregnant (female patients), but will inform staff if I am pregnant at future treatments.
- _____ I understand that I must wait for one month after the completion of all laser treatment sessions before tanning.
- _____ I understand that I must wear a sunblock with a minimum of 5% zinc oxide or better following treatment and in the future to maximize my skin protection and laser results.
- _____ I understand the 24-hour notice policy for cancelled or rescheduled appointment and the loss of a package session or a \$50 fee if I fail to comply.

I have been given the opportunity to ask questions about the procedure. My questions have been answered and I understand the information given to me. I acknowledge that no guarantees have been made to me concerning the results of laser treatment.

If I have any questions about my treatment or post-treatment care, I have been instructed to contact the office 505-338-4038 during business hours and 505-857-3999 for emergencies after hours.

I have read and understood all information presented to me before signing this consent form.

Signed: _____ Date: _____

Witness: _____ Time: _____