CONSENT FOR PULSED LIGHT/LASER TREATMENTS

I give my consent and authorization to Ascension Center for Women's Health to treat me with cosmetic laser and/or pulsed light modalities. This includes, but is not limed to, photo-facials, fractional laser skin resurfacing, laser and intense pule light, hair removal, pigmented lesions treatment, vascular lesions, and toenail fungus.

I understand that these procedures are purely elective, that the results may vary with each individual, no guarantee can be provided in regards to the outcome of medical procedures such as these, and multiple treatments may be necessary to achieve maximum results.

I acknowledge and understand that:

- Serious complications are rare, but possible.
- Common side effects include temporary redness and mild "sunburn" like side effects and may last anywhere from a few hours to 3-4 days.
- Pigment changes, including hypopigmentation (lightening of skin) or hyper-pigmentation (darkening of skin) lasting 1-6 months or longer, may occur.
- Freckles may temporarily or permanently disappear in treated areas.
- Other potential risks include crusting, itching, pain, bruising, burns, infection, scabbing, scarring, swelling, and failure to achieve the desired results.
- Laser and intense pulse light treatments can cause eye injury and protective eyewear must be worn during all treatments.
- I understand that sun or tanning lamp exposure and not adhering to the post-care instructions provided by Ascension Center for Women's Health may increase may chances of complications.

I consent to photographs being taken for use in the follow areas: evaluation of treatment effectiveness, medical education, and training, marketing, media, media stories, advertising, and other sales purposes. No photographs revealing my identity will be used without, my written consent. If my identity is not revealed, these photographs may be displayed publicly without my permission.

I acknowledge that pre-and post -treatment instructions have been discussed with me. The procedure as well as potential benefits and risks have been explained to my satisfaction. I have had all my questions answered. I freely consent to the treatments.

Client Signature: ______________________________ Date: __________

Print Name: ______________________________ Date: __________

Witness Signature: ______________________________ Date: __________