PICOLAZER TATTOO REMOVAL CONSENT

1. Procedure Description and Eye Safety

The PicoLazer laser produces an intense burst of laser light. The sensation of the laser light on skin can be uncomfortable and may feel like a slight pinprick or the sensation of heat. These sensations may last for a few hours.

All personnel in the treatment room, including me, will wear protective eyewear to prevent eye damage from this intense light. I agree to keep this eyewear on at all times during the procedure. ____ **(Initial)**

2. Medical History & Contraindications Verification

I confirm that I have truthfully disclosed all medical conditions, current health status, medications, and supplements to the service provider.

I understand that recent sun exposure or tanning (natural or artificial) must be strictly avoided for at least two weeks prior to treatment, as it significantly increases the risk of complications. ____ **(Initial)**

I will notify my service provider immediately if there are any changes to my medical history including new medications or supplements.

3. Informed Consent, Alternatives, and Guarantees

I understand that this is an elective procedure and fully consent to the PicoLazer treatment.

Alternatives: I acknowledge that I have been informed of alternative treatments, including the option of no treatment, and the potential risks and benefits of these alternatives have been discussed. ____ **(Initial)**

No Guarantee: I understand that laser treatment is not an exact science and that **no specific result, outcome, or percentage of improvement is guaranteed or warranted**, and I accept the possibility of a result that is less than expected. ____ **(Initial)**

4. Specific Risks and Complications Disclosure

I accept the possible complications of the procedure and have been specifically informed of the risks, which may be temporary or permanent.

LUXE MEDICAL

5. Post-Treatment and Financial Responsibility

Post-Care Compliance: PicoLazer pre- and post-treatment instructions have been reviewed and provided to me. I understand that **not adhering to the care instructions provided, including rigorous sun protection,** may increase my risk of complications.

Financial Responsibility: I understand that I am financially responsible for the cost of the PicoLazer treatment(s), and I acknowledge that all fees paid are non-refundable. I am also responsible for any subsequent medical costs incurred due to complications (e.g., prescriptions, specialist visits).

6. Liability Waiver (Indemnification)

I understand that multiple treatments may be necessary.

I have read and understand all information presented to me. I have been given an opportunity to ask questions before signing this consent.

I hereby indemnify and hold harmless Luxe Medical from any and all liability, damages, cost and expenses arising from or out of the use of the PicoLazer.

I agree to have before and after photographs taken of the treatment area. ____ **(initials)**

Patient: _____ Date: _____

Witness: _____ Date: _____

LUXE MEDICAL