PICOLAZER SKIN REJUVENATION CONSENT

I. PROCEDURE AND CONSENT

I understand this is an **elective procedure** and fully consent to the PicoLazer treatment. The PicoLazer laser produces an intense burst of laser light.

The procedure, including the benefits, risks, and potential side effects, has been fully explained to me. I accept the possible complications of the procedure and I understand that **no guarantees are implied** as to the outcome of the procedure.

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

II. SPECIFIC RISK AND INSTRUCTION ACKNOWLEDGMENT (PLEASE INITIAL EACH LINE)

By initialing below, I confirm I have been informed of and understand the following:

- I understand the sensation of the laser light on skin can be uncomfortable and may feel like a slight pinprick or the sensation of heat. _____ **(initials)**
- I understand these sensations may last for a few hours. _____ **(initials)**
- I understand that all personnel in the treatment room, including me, will wear protective eyewear to prevent eye damage from this intense light. _____ **(initials)**
- I understand that temporary side effects may include redness, swelling, blistering, and changes in skin color (hyperpigmentation or hypopigmentation). _____ **(initials)**
- I understand that **multiple treatments may be necessary**. _____ **(initials)**
- PicoLazer pre- and post-treatment instructions have been reviewed and provided to me. _____ **(initials)**
- I understand that **not adhering to the care instructions provided may increase my risk of complications**. _____ **(initials)**

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

III. LIABILITY AND FINANCIAL RESPONSIBILITY

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.

Financial Responsibility and Follow-Up Care I understand that this is an elective procedure and I am personally and **financially responsible** for the cost of the PicoLazer treatment. I further understand and agree that I am responsible for the costs of any required medical care or treatment by external medical providers (e.g., dermatologist, general practitioner, urgent care) necessitated by any complication arising from this treatment. I agree to notify my service provider immediately if I experience a severe or unexpected reaction.

IV. PHOTOGRAPHY AND SIGNATURES

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

Patient: _____ Date: _____

Witness: _____ Date: _____