LIGHT BASED TREATMENT CONSENT FORM

Title _____ Full Name_____Date_____

Please initial each paragraph and sign below

_____ I authorise Dr Lisa Mason, XORA Health, and any designated employee to use laser and/or IPL/RF to reduce pigmented or vascular lesions and/or unwanted hair. I understand the procedure is purely elective, the results may vary with each individual and that multiple treatments may be necessary.

_____ I will wear protective eyewear to prevent eye damage.

_____ I understand the treatment of benign pigmented and vascular lesions may not be successfully accomplished without possibly producing some epidermal damage that may take 2 or more weeks to resolve.

_____ I understand that sun exposure or use of tanning lamps or self tanning creams and not adhering to the post-care instructions provided to me, will increase my chance of complications including hyperpigmentation.

_____ I have not exposed the treatment area to the sun / tanning lamps or self tanning creams for the last 6 weeks.

_____ I have had the brown spots on my skin checked by a skin physician prior to treatment, as treatment of an undiagnosed skin cancer may delay proper medical care, and mask symptoms of more serious issues.

_____ I understand that serious complications are rare, but possible. Common side effects include temporary redness and mild 'sunburn' like effects & sensations, that may last a few hours to 3-4 days or longer.

_____ The sensation of light is sometimes uncomfortable and may feel like a moderate to severe pinprick or burst of heat. Pigment changes (light or dark spots on the skin) lasting 1-6 months or longer may occur.

_____ Freckles may lighten and/or temporarily or permanently disappear in treated areas. There is the likelihood of coincidental hair removal when treating pigmented/vascular lesions in hair bearing areas.

_____ Other potential risks include crusting, itching, pain, bruising, skin whitening, burns, blisters, infection, scabbing, scarring, swelling and failure to achieve the desired result.

_____ I understand that light treatment can trigger a herpes outbreak and agree to taking medication before and after the procedure.

_____ I am not pregnant.

_____ I consent to photographs being taken to evaluate treatment effectiveness, for medical education, training, professional publications or sales purposes. No photos revealing my identity will be used without consent. If my identity is not revealed, these photographs may be used and displayed publicly without my permission.

_____

NAME SIGNATURE DATE