This form is designed to ensure you are provided with the information needed to decide on your treatment plan utilizing the Lutronic® LaseMD Ultra™ laser platform. If you have questions or need clarification on any aspect of this consent form or on your treatment plan, please do not hesitate to ask.

CLIENT NAME (PRINT):

Please read each of the following statements and initial next to each if you consent. If you have any questions or would like further information, do not hesitate to ask.

CLIENT GUIDE

I have reviewed and understand the following information given in the LaseMD Ultra Client Guide:

_____ Benefits of Treatment

_____ Possible Side Effects

_____ Home Care Instructions

_____ Important Reminders

UNDERSTANDING OF PROCEDURE AND ALTERNATIVES

TREATMENT PLAN

_____ **A comprehensive treatment plan has been discussed with me** and I understand, for best results, it's highly recommended that I complete my treatment plan. The nature of treatment with any fractionated laser platform is based on **completing a series of treatments spaced about four (4) weeks apart.**

_____ I have provided an accurate health history, including all current conditions and medications I am taking, to THE YOUNG EXPERIMENT LLC. I understand that omitting or altering information, whether intentional or not, may put me at risk for adverse events. I also agree to inform my provider if anything changes in my health history while I am a client at THE YOUNG EXPERIMENT LLC.

POTENTIAL RISKS AND ADVERSE EVENTS

_____ **I acknowledge that, while serious complications are rare, they are possible.** Potential adverse events include:

- Temporary redness and mild “sunburn-like” effects (lasting a few hours to 4+ days).
- Changes in skin pigmentation (lightening or darkening) lasting 1 to 6+ months.
- Itching/Discomfort
- Bruising
- Blistering
- Swelling
- Risk of scarring at the treatment site.
- Risk of eye injury if protective eyewear is not properly worn (protective eyewear will be provided).

PRE- AND POST-TREATMENT INSTRUCTIONS

_____ **I acknowledge that the home care instructions have been discussed with me** and I understand the importance of following them to ensure the best results and minimize risks.

_____ I agree to follow the provided instructions and will contact THE YOUNG EXPERIMENT LLC before making any changes. **I understand that disregarding these guidelines may compromise my treatment results.**

PHOTOGRAPHY CONSENT

_____ **I consent to clinical photographs being taken** for the following purposes:

- Evaluating treatment progress
- Medical education and training

_____ I understand this consent **does not include photos/videos used for marketing purposes** as that is a separate, more specific release form.

CONSENT TO PROCEED

The procedure, benefits, risks, and alternatives have been explained to my satisfaction.

All of my questions have been answered.

I voluntarily consent to proceed with the proposed treatment plan.

I certify that I am a competent adult (18 years of age or older), or if under 18, that a parent, legal guardian, or authorized representative will provide consent before treatment.

Client Name (Print): _____

Client Signature: _____

Date: _____

Provider Signature: _____

Date: _____