TREATMENT INFORMED CONSENT

PATIENT CONSENT TO TREATMENT

My signature below constitutes my acknowledgement that:

1. I,_________________________ consent to and authorize __________________ and staff members to perform laser-assisted skin care treatments and related services on me.

2. The nature and purpose of the treatment have been explained to me and any questions I have had regarding the treatment have been answered to my satisfaction.

3. I acknowledge that I have revealed any current or previous condition that may affect the outcome of the treatment (including but not limited to Photosensitive condition, auto-immune deficiency, herpes, pregnancy, hormonal disease, allergies, etc.) and that I have revealed any use of medications (including but not limited to anti-coagulants, Rogaine®, etc.).

4. I understand that the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks. Possible side effects of the area treated can include mild redness of the skin, irritation, local swelling, mild discomfort or tenderness, pinpoint bleeding, bruising, pimple like bumps, lightening or darkening of the skin and a small risk of scarring.

5. I understand that I have the right to refuse treatment.

6. Due to the nature of this treatment, exact results cannot be predicted, and I acknowledge that no guarantees have been made to me as to the results that may be obtained. I further understand that no promises of permanence have been made to me regarding any laser or skin care treatments.

7. I certify that I have read this entire informed consent and that I understand and agree to the information provided orally and in this form. I certify that I am a competent adult over 18 years of age. This informed consent is freely and voluntarily executed and shall be binding upon my spouse, relative, legal representatives, heirs, administrators, successors and assigns.

8. I agree to adhere to all safety precautions and regulations during the laser treatment.

9. I have received and understand post treatment skin care recommendations.

10. I agree to pay $_________ for the above-mentioned services and understand that there will be no refund for any performed services.

PATIENT SIGNATURE: ______________________________________ DATE: __________________

FOR PROVIDER COMPLETION:

The undersigned hereby certifies that he/she discussed with the above-named person all the foregoing matters, including the risks and benefits of the treatment and that the discussion in his/her judgment was adequate and reasonable. In addition, the patient was encouraged to ask questions and all questions were answered.

SIGNATURE: ______________________________________ DATE: __________________

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