INFORMED CONSENT FOR
Nd:YAG 1064NM LASER PROCEDURES

I, _____, have given Dr. _____ permission to
(Patient's name)

perform Nd:YAG laser procedures on my _____ .
(area to be treated)

The LightPod Neo® (Nd:YAG 1064nm) laser is FDA approved for a variety of procedures including hair removal, vein treatment and wrinkle reduction. This form is designed to give you the information you need to make an informed choice of whether or not to undergo Nd:YAG laser treatment. If you have any questions, please do not hesitate to ask. Although the laser treatment is effective in most cases, no guarantee can be made that a specific patient will benefit from the treatment.

The laser emits an intense beam of light that is absorbed in specific body tissues within the skin, and depending upon the type of procedure, several treatments may be required at intervals specified by the physician.

Some of the possible complications of Nd:YAG laser treatment are:

1. Discomfort – The procedure is done so precisely that surrounding tissue is minimally affected; the patient may experience a mild sensation of pain in the treated areas. Some degree of skin flushing may occur, but it typically resolves within several hours.

   Initials_____

2. Scarring – There is a small chance of scarring, including hypertrophic scars, or very rarely, keloid scars. Keloid scars are very heavy raised scar formations. To minimize chances of scarring, it is important that you follow all postoperative instructions carefully. It is important that any prior history of unfavorable healing be reported.

   Initials_____

3. Pigmented changes – The treated area may heal with lighter or darker pigmentation. This occurs more often in darker pigmented skin and following exposure of the area to the sun. It is recommended that you protect yourself from any sun exposure for at least three months following treatment. Hyperpigmentation usually fades in three to six months. However, pigment change can be permanent.

   Initials_____

4. HSV Reactivation – The patient agrees to notify the physician if he/she has any history of Herpes viral infections, as the laser procedure may cause it to reactivate.

   Initials_____

5. Lack of Treatment Response – There is a possibility that the targeted hairs, veins or other treated areas will not respond to the treatment. This is often a function of the specific body chemistry of the patient, including relative pigmentation and light absorption characteristics of the patient's various body tissues.

   Initials_____

6. Eye Exposure – There is also the risk of harmful eye exposure to laser surgery. Safeguards should be provided by the laser practitioner. It is important that you keep your eyes closed and have protective eye wear at all times during the laser treatment.

   Initials_____

7. Photographs – I consent to be photographed before, during, and after the treatment and that these photographs shall be the property of the above doctor and may be published in scientific journals or for scientific or marketing reasons.

   Initials_____

Additional risks and alternatives:

_____
_____
_____

I certify that I have read or have had read to me, the content of this form. I understand the risks and alternatives involved in this procedure. I have had the opportunity to ask ay questions that I had and all of my questions have been answered.

Signed: _____ Date: _____ Time: _____
(Patient or person authorized to consent for patient)

Witness: _____ Date: _____ Time: _____