



PATIENT INFORMED CONSENT FORM TEMPLATE*
FOR GENESIS SKIN THERAPY
Laser Genesis, GenesisV, GenesisPlus

I hereby authorize Dr. _____ or _____, under Dr. _____'s supervision to perform Genesis Non-Ablative Skin Therapy on me. I understand that this procedure works on promoting vibrant and healthy looking skin. I understand that multiple treatments are required and it is possible the result will be minimal or not help at all.

I am aware of the following possible experiences/risks:

- DISCOMFORT – A slight warming sensation may be experienced during treatment.
- REDNESS/SWELLING/BRUISING – Short term redness (erythema) or swelling (edema) of the treated area is common and may occur. There also may be some bruising.
- SKIN COLOR CHANGES – During the healing process, there is a possibility that the treated area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- ITCHING/DRY SKIN – Treatment may result in itching and/or dry skin.
- RED RASH/BUMPS – Red rash/bumps may appear after treatment. This resolves with time.
- WOUNDS – Treatment can result in burning, blistering, or bleeding of the treated areas. If any of these occur, please call our office.
- INFECTION – Infection is a possibility whenever the skin surface is disrupted, although proper wound care should prevent this. If signs of infection develop, such as pain, heat, or surrounding redness, please call our office __ (Phone number) _____.
- SCARRING – Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.
- SUN EXPOSURE / TANNING BEDS / ARTIFICIAL TANNING - May increase risk of side effects and adverse events.
- EYE EXPOSURE – Protective eyewear (shields) will be provided to you during the treatment. Failure to wear eye shields during the entire treatment may cause severe and permanent eye damage.

I acknowledge the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me
- Alternative treatments such as topicals, microdermabrasion, or surgery
- Reasonably anticipated health consequences if the procedure is not performed.
- Possible complications/risks involved with the proposed procedure and subsequent healing period

For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep Dr. _____ and staff informed should I become pregnant during the course of treatment.

Photographic documentation will be taken. I hereby do ___ do not ___ authorize the use of my photographs for teaching purposes.

ACKNOWLEDGMENT

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FOR LASER GENESIS TREATMENT, AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.

Signature-Patient or Guardian

Print Name/Relationship

Date

Signature-Witness

Print Name

Date