**PATIENT INFORMED CONSENT FORM TEMPLATE***
FOR TREATMENT OF ACNE

I hereby authorize Dr._____ or _____, under Dr. _____'s supervision to treat my acne using a laser device. I understand that multiple treatments may be required and it is possible the result will be minimal or may not help at all.

The procedure may result in the following adverse experiences or risks:

- DISCOMFORT/PAIN –Discomfort and pain 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.
- URTICARIC REACTION – Localized rash with or without redness and/or itching may appear up to 48 hours post-treatment. An anti-histamine can be administered or hydrocortisone can be applied. Symptoms should resolve within a few days.
- WOUNDS – Deep tissue injury and prolonged wound healing may occur. 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, though 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 treatment of acne, including the possibility that the procedure may not work for me.
- Alternative treatments such as topical or oral medications or even 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. Futhermore, 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 FORM FOR TREATMENT OF ACNE, AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.**

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| **Signature-Patient or Guardian** | **Print Name/Relationship** | **Date** |
| **Signature-Witness** | **Print Name** | **Date** |