INFORMED CONSENT FOR INTENSE PULSED LIGHT (IPL) THERAPY SKIN TREATMENT
(Lumenis Stellar M22®)

I authorize JaLaine Aesthetics and Wellness, PLLC, and associates to perform IPL treatments on me in an effort to improve Dyschromia/Hyperpigmentation/Hair Reduction/Port Wine Stains/Hemangioma/Angioma/Rosacea/Telangiectasia/Mild to Moderate Inflammatory Acne

I understand that there is a rare possibility of side effects or serious complications including permanent discoloration and scarring. I am aware that careful adherence to all advised instructions will help reduce this possibility.

I understand the below list of short-term effects and agree to follow the matching guidelines:

- Flaking of pigmented lesions – crusts may take 5 to 10 days to disappear and it is important not to manipulate or pick which may otherwise lead to scarring
- Discomfort – during the procedure, I might experience a sensation similar to a rubber band snap which degree will vary per my skin condition and area sensitivity but that does not last long. A mild "sunburn" sensation may follow for typically up to one hour and will be reduced with the application of cooling and soothing creams
- Reddening and swelling – severity and duration depend on the intensity of the treatment and the sensitivity of the area to be treated. These phenomena may be reduced with the application of cooling and/or anti-inflammatory creams
- Bruising may rarely occur and may last up to 2 weeks

I understand that sun exposure or tanning of any sort is not aligned with the pre and/or post care instructions and may increase the chance for complications.

The procedure as well as potential benefits and risks have been thoroughly explained to me and I have had all my related questions answered.

Pre and post-care instructions have been discussed and are completely clear to me.

I understand that results may vary with each individual and acknowledge that it is impossible to predict how I will respond to the treatment and how many sessions will be required.

I consent to photographs being taken for the purpose of documenting my progress and response to the treatment and be kept solely in my medical record.

I consent to photographs being used for medical education or publication with applied discretion and not revealing my identity.

Initial _____

INTRODUCTION

I CONSENT TO THE TREATMENT OR PROCEDURE AND UNDERSTAND THE INFORMED CONSENT FORM, AND I AM SATISFIED WITH THE EXPLANATION.

_____ _____

Client Signature Date

_____ _____

Witness Date