

PATIENT CONSENT FORM
FOR LASER GENESIS SKIN THERAPY

PATIENT/CLIENT NAME:

ATTENDING PHYSICIAN:

I hereby authorize Dr. William J. Hedden to perform Laser Genesis Non-Ablative Skin Therapy on me. I understand that this procedure works on promoting vibrant and healthy looking skin. The Laser Genesis procedure is a revolutionary way to combat the signs of aging, without harsh chemicals or long recovery periods.

The following points have been discussed with me:

- The potential benefits of the proposed procedure.
- The possible alternative procedures.
- The probability of success.
- The reasonably anticipated consequences if the procedure is not performed.
- The most likely possible complications/risks involved with the proposed procedure and subsequent healing period; including, but not limited to, infection, scarring and/or blistering.

I am aware of the following possible experiences/risks with Laser Genesis:

- DISCOMFORT – A slight warming sensation may be experienced during laser treatment.
- WOUND HEALING – Any laser procedure can result in swelling, blistering, crusting, or flaking of the treated areas, which may require one to three weeks to heal.
- BRUISING/SWELLING/INFECTION - With some lasers, bruising of the treated area may occur. Additionally, there may be some swelling noted. Finally, skin infection is a rare possibility whenever a skin procedure is performed.
- PIGMENT CHANGES (Skin Color) – There is a slight possibility that the treated area can become either hypopigmented (lighter), or hyperpigmented (darker), in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- SCARRING – Scarring is a rare occurrence, but it is a possibility if the skin’s surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions carefully.
- EYE EXPOSURE – Protective eyewear (shields) will be provided. It is important to keep these shields on at all times during the treatment in order to protect your eyes from accidental laser exposure.
- TREATMENTS – The number of treatments may vary. The number of treatments needed to clear your pigmented lesion is unknown.

ACKNOWLEDGMENT

I UNDERSTAND AND ACKNOWLEDGE THAT PAYMENTS FOR THE ABOVE PROCEDURE ARE NON-REFUNDABLE.

BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS PERMISSION FORM FOR LASER HAIR REMOVAL TREATMENT AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.

Signature-Patient or Guardian

Print Name/Relationship

Date

Signature-Witness

Print Name/Relationship

Date