

PATIENT CONSENT FORM
FOR PIGMENTED LESION THERAPY

PATIENT/CLIENT NAME:

ATTENDING PHYSICIAN:

I hereby authorize and direct any associates or assistants of Dr. William J. Hedden to perform pigmented lesion treatment on me. I understand that this procedure works on removing pigmented lesions, age and sun spots by targeting the areas to be treated with a bright pulsed light. I hereby confirm I had a discussion with my physician/nurse regarding pulsed light therapy and its benefits and consequences. I will wear protective eye goggles to prevent any eye damage from pulsed light. Anesthesia is not required in most cases. All options will be discussed with me in case anesthesia is used.

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, blistering and pigmentary changes.
- Photographs will be taken and may be used for educational purposes.
- Post treatment instructions.

I am aware of the following possible experiences/risks:

- DISCOMFORT – A mild pain may be experienced during treatment.
- WOUND HEALING – While not expected, some swelling or blistering of the treated area may occur. Skin infection is a rare possibility whenever a skin procedure is performed.
- POST TX – Typically, the treated areas will darken and crusting or flaking will occur for 1 to 3 weeks after treatment.
- 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 pulsed light 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