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CONSENT FOR PHOTOFACIAL/SKIN REJUVENATION (IPL)

I _____ consent to and authorize Body Focus Laser & Longevity Center to perform treatments. Light can be used to destroy located targets on the skin with minimum damage to the surrounding tissues. Light is used to lighten or remove photo-damaged skin in a nonablative manner, a procedure known as *photo rejuvenation.* Visible signs of photo damage include wrinkles, enlarged pores, course skin texture, and pigment alterations.

Phototherapy, despite its high levels of efficacy and safety, is not free of side effects. Erythema (redness) and edema (swelling) of the treated area can occur but usually subsides within a few hours up to seven days or longer. Irritation, itching, and/ or a mild burning sensation or pain to sunburn may occur within 48 hours of treatment.

Pigmentary changes, such as, hyper-pigmentation (browning) and hypo-pigmentation (whitening) of the skin in the treated areas can occasionally occur. Mostly it is transient, lasting up to 6 months, but in rare cases it can be permanent. Most cases of hypo or hyper-pigmentation occur in people with darker skin or when the treated area has been exposed to sunlight before or after treatment. Occasionally these pigmentary changes occur despite appropriate protection from the sun.

Scarring, which can be hypertrophic or even keloid, is very rare but can occur. Other known complications of this procedure include blisters, redness, scaring, bruising, superficial crusting, burns, pain, and infections. These side effects are usually temporary, lasting from five to ten days but can be permanent as well.
_____Initials

Additionally, there is a known and expected loss of hair in the treated areas. In a very small percent of people there is new hair growth in the surrounding areas being treated.
_____ Initials

Even though appropriate measures are taken to reduce side affects, they cannot be completely eliminated is every case. I understand that the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks. There may be other treatment options, such as injections, other types of laser/light sources or peels. With this in mind, I am choosing this non-invasive treatment for vascular and/or pigment lesions and other indicated skin conditions.
_____Initials

Eye damage can occur from the light and therefore protective eyewear must be worn during all photo-therapy sessions.
_____Initials

I have read and understand the Pre and Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre and procedure guidelines are crucial for healing, prevention of scarring, and other side effects and complications such as, hyper pigmentation, hypo-pigmentation, and other skin textural changes.
_____Initials

I understand that this examination is not meant to replace the necessity for a complete dermatological examination.

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Photographs: I give permission for my photographs to be used to help document my treatment course. Complete confidentially will be maintained.
_____Initials

No guarantee, warranty, or assurance has been made to me as to the result that may be obtained. I am aware that follow-up treatments maybe necessary for desired results. Most patients require a number of treatments over several months with gradual results occurring over time. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for any paid treatment.
_____Initials

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

I release Body Focus Laser & Longevity Center from liability associated with this procedure.

Patient Signature: _____ Date _____/_____/_____