MEDICAL AESTHETICS

HINGHAM | EASTON | MILTON

LUXEA LASER/IPL® CONSENT FORM

WWW.MEDICALAESTHETICSMA.COM

HINGHAM
38 North Street
Hingham, MA 02043
781.556.5676

EASTON
244 Washington Street
North Easton, MA 02356
508.219.2113

MILTON
524 Adams Street
Milton, MA 02186
617.322.1852

THE PROCEDURE MAY RESULT IN THE FOLLOWING ADVERSE EXPERIENCES OR RISKS:

DISCOMFORT/PAIN:

Some discomfort and/or pain may be experienced during treatment, but is unlikely.

REDNESS/SWELLING/BRUISING:

Redness (erythema) or swelling (edema) of the treated area is common and may occur. There also may be some bruising.

HYPOPIGMENTATION / HYPERPIGMENTATION (CHANGES IN SKIN COLOR):

During the healing process, there is a slight 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.

WOUNDS:

Treatment can result in burning, blistering, or bleeding of the treated area(s), but is unlikely.

SUN EXPOSURE / TANNING BEDS / ARTIFICIAL TANNING:

May increase risk of side effects and adverse events. If any of these occur, please call our office.

INFECTION:

Infection is a possibility whenever the skin surface is disrupted, although proper wound care should prevent this. If signs of infection develop, such as pain, heat, or surrounding redness, please call our office.

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.

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.

AUTHORIZATION (S)

I acknowledge the following points have been discussed with me:

_____ (Patient Initials) Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me.

_____ (Patient Initials) Alternative treatments and my options.

_____ (Patient Initials) Reasonably anticipated health consequences if the procedure is not performed.

_____ (Patient Initials) Possible complications/risks involved with the proposed procedure and subsequent healing period.

_____ (Patient Initials) 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.

_____ (Patient Initials) Photographic documentation will be taken for teaching and before/after purposes. I hereby ☐ do ☐ do not authorize the use of my photographs and understand that all attempts will be made to conceal my identity.

I, _____ hereby authorize _____ to perform a LUXEA treatment on me. I understand that this procedure may be used to for: laser hair removal, laser vein reduction, laser tattoo removal, intense pulsed light, fractional laser resurfacing, benign sun/age spot removal, benign superficial vascular lesions removal, photofacial, skin tig htening, wrinkle reduction, Acne, Acne Scarring, etc. I understand that I may require several treatments to obtain a significant, long-term results. I understand I may experience redness, dryness, sloughing of the tissue, mild to moderate sunburn sensation and or bleeding post treatment. I understand all the potential side effects, as discussed with me prior to treatment. I understand that genetics, hormones, medication and skin color may interfere with the ability to perform an effective treatment.

PATIENT SIGNATURE DATE TIME

and/or

RESPONSIBLE RELATIVE OR GUARDIAN RELATIONSHIP

PROVIDER'S NAME PROVIDER'S SIGNATURE