INFORMED CONSENT – LASER GENESIS SKIN THERAPY

TO THE PATIENT:

Being full informed about your condition and treatment will help you make the decision whether or not to undergo a Laser Genesis Skin Therapy treatment. This disclosure is not meant to alarm you; it is simply an effort to better inform you so that you may give or withhold your consent for this treatment.

I hereby authorize The Medical Director(s) or any delegated associates to perform Laser Genesis Non-Ablative Skin Therapy on me. I understand that this procedure works on promoting vibrant and healthy looking skin by creating a thermal response in the dermis that stimulates new collagen. I understand that multiple treatments are required and it is possible the result will be minimal or not help at all.

_____

(Patient's Name)

I am aware of the following possible experiences/risks:

- DISCOMFORT – Some discomfort may be experienced during treatment.
- REDNESS/SWELLING/BRUISING – Short term redness (erythema) or swelling (edema) of the treated area is common and may occur. There also may be some bruising.
- PIGMENT CHANGES (Skin Color) – During the healing process, there is a possibility that the treated area can 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 areas. 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 Alamo Hills Advanced Aesthetics & Laser Center.
- SCARRING – Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the changes 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 injury.

INFORMED CONSENT – LASER GENESIS SKIN TREATMENT

The following points have been discussed with me:

- Potential benefits of the proposed procedure
- Probability of success
- Reasonably anticipated consequences if the procedure is not performed
- Most likely possible complications/risks involved with the proposed procedure and subsequent healing period
- Post-treatment instructions

For women of childbearing age: By signing below I indicate that I am not pregnant. Futhermore, I agree to keep The Medical Director(s) and staff informed should I become pregnant during the course of treatment.

Photographic documentation will be taken. I hereby **do**___**do not**___ authorize the use of my photographs for teaching purposes.

_____I consent and authorize a trained physician, registered nurse, physician assistant, or nurse practitioner of Alamo Hills Advanced Aesthetics & Laser Center to perform Laser Genesis treatments.

Patient Consent

I certify that I have read and understand this treatment agreement and that all the blanks were not filled prior to my signature.

_____	_____	_____
Patient Signature	**Print Name**	**Date**
_____	_____	_____
Witness Signature	**Print Name**	**Date**

Physician or Clinician Certification

I certify that I have explained the nature, purpose, benefits, risks, complication and alternatives to the proposed procedure to the patient. I have answered all questions fully and I believe that the patient fully understands what I have explained.

_____	_____
Clinician Signature	**Date**

Alamo Hills Advanced Aesthetics & Laser Center