V-Lase Vaginal Rejuvenation Consent Form
Alamo Hills Advanced Aesthetic & Laser Center (AHAA&LC)

Patient Name (Print Please): ________________________________

Birthdate: ____/____/____

I, ______________________________________ voluntarily request the V-Lase minimally invasive procedure. I voluntarily consent and authorize that this minimally invasive procedure to be performed by Dr. Abdul Nawabi or a designated healthcare professional appointed by Dr. Nawabi.

I hereby release Alamo Hills Advanced Aesthetics & Laser Center and Nawabi's Wellness, its staff, and any other participating health care providers from any and all liability for any adverse effects that may result from this treatment and related procedures.

For the purpose of accurate record keeping in connection with the care and treatment which I am receiving and will subsequently receive from AHAA&LC and Nawabi's Wellness, I consent to have Dr. Nawabi or staff member take before, during, and after treatment close-up photographs of the involved area(s) and the anatomical region surrounding the involved area(s). These photographs shall be used for medical records and shall be treated with the same confidentiality as the remainder of my record at AHAA&LC AND Nawabi's Wellness.

I recognize that this minimally invasive procedure is not an exact science and I acknowledge that no guarantee or assurances have been made to me as to the result or cure. There are risks related to the performance of these procedures. I understand and acknowledge that the risks that may occur in connection with this particular procedure may include the following:

• **Infection** – Albeit rare, infection is a possibility any time a procedure is performed. I acknowledged and understand that although rare it is possible for an infection to become a blood-borne widespread infection.

• **Bruising** – Bruising in the treated area is possible, especially if within the last ten (10) days, I have taken aspirin or aspirin-containing products, or other medications that "thin" the blood.

• **Discomfort** – Minimal discomfort will be experienced during and after the laser treatment. I give my permission for the administration of topical and/or local injection of anesthesia when and if deemed appropriate.

• **Poor healing** – The vagina may require more than the usual three days to heal.

I understand and acknowledge that I have been informed by individual discussion, that multiple treatments are often required to cause long term results and that some patients have no results even with multiple treatments. The usual number of treatments required is two to three, but more treatments may be required.

I have been given an opportunity to ask questions about my condition, alternative forms of anesthesia (topical numbing cream) and treatment, the procedure to be used, and the risks and hazards involved, and I believe that I have sufficient information to sign the informed consent. By signing below, I certify that I have read and fully understand the contents of this document and that I have received and understand all of the disclosures referred to herein. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian having legal custody will also be required before treatment.

______________________________________ _____/_____/_____

Patient Signature Date

______________________________________ _____/_____/_____

Clinician Signature Date