LASEMD TREATMENT CONSENT FORM

This form is designed to provide you with the information you need to make an informed decision on whether or not to have a LASEMD Laser Treatment procedure performed. If you have any questions or do not understand any part of this consent, please do not hesitate to ask us.

I hereby authorize **[INSERT FACILITY NAME]** to perform laser treatment on me. I understand that the procedure is purely elective and I have chosen to receive treatment for:

- ❑ Treatment of Benign Pigmented Lesion to:_____(area)
- ❑ Treatment of _____ to:_____(area)
- ❑ Treatment of _____ to:_____(area)

I understand the nature of my condition, the nature of the procedure, the alternative treatments available, and the benefits to be expected compared with alternative approaches. I understand that optimal results are achieved only with a series of treatments and that I will not see optimal results after one treatment. The need to complete a treatment plan has been fully explained to me.

Just as there are benefits to the procedure proposed, I understand that this procedure also involves risks. I understand that serious complications are rare but possible. Common side effects include temporary redness and mild "sunburn" like effects that may last a few hours to 3-4 days or longer. Pigment changes (light or dark spots on the skin) lasting 1-6 months or longer may occur. Other potential risks include itching, pain, bruising, blistering, redness and swelling. There is a rare possibility that a scar at the treatment site may develop. Laser light can cause eye damage and provided protective eye wear must be worn during treatment.

I consent to photographs being taken to evaluate treatment effectiveness, for medical education and training. No photographs revealing my identity will be used without my written consent.

"Before and After Instructions" have been discussed with me. The procedure, as well as potential benefits and risks, have all been explained to my satisfaction. I have had all my questions answered. I freely consent to the proposed treatment. 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/person having legal custody will also be required before treatment.

Patient Signature	Print Patient Name	Date

Physician Signature	Print Phycisian Name	Date