

# INFORMED CONSENT

## For Removal/Reduction of Brown/Age Spots, Rosacea, Acne & Spider Veins

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(First) (Last)

I authorize Evergreen Laser to perform the procedure. The pulsed light system may dramatically reduce darkly pigmented sun spots and spider veins. More than one laser session may be necessary to achieve desired results. However, other treatments, including skincare products, are often needed to blend color, reduce sun damage, and give the best results.

The FDA has given the clearance to remove brown spots, spider veins, and rosacea. The skin treated will be red and swollen, with fine, thin scabs forming. Keep the treated areas covered with Polysporin and Aquaphor until the thin scabs fall off. This process will take anywhere from 1-3 weeks.

It could take as long as 3-6 months in some rarer cases.

Do not scratch the scabs, as that can cause scarring. **We are unable to treat clients that are on ACCUTANE and PHOTSENSITIZING medications. Clients using ANTICOAGULANTS should be noted.**

This form is designed to provide detailed information regarding the Removal/Reduction of Brown/Age Spots, Rosacea, Acne & Spider Veins (hereinafter the "Treatment"). Please read this form thoroughly and make sure all your questions are answered before deciding to undergo treatment. After reading this document, **please initial** each section, and date the appropriate areas.

The possible side effects of Removal/Reduction of Brown/Age Spots, Rosacea, Acne & Spider Veins include but are not limited to:

**x \_\_\_\_\_ Scarring:** The pulsed light system can create bruising and a moderate burn or blister to the skin. For an effective treatment, the power (joules) needs to be below the blistering point, which means the skin will be red. There is a risk of scarring.

**x \_\_\_\_\_ Hyper-pigmentation** (browning) and **Hypo-pigmentation** (whitening) have been noted after treatment, especially with a darker complexion. This usually resolves within weeks, but it can take as long as 3-6 months in some cases. Permanent color change is a rare risk. If you have much color in your skin, a skin lightening cream will be advised to reduce the melanin in your skin before the treatment. Avoiding sun exposure after the treatment is crucial to reduce the risk of color change.

**x \_\_\_\_\_ Infection:** Although infection following pulsed light treatment is unusual, bacterial, fungal, and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a laser treatment. This applies to both individuals with a history of herpes simplex virus infections in the mouth area. Should any skin infection occur, additional treatment, including antibiotics, might be necessary. **If you have a history of the herpes simplex virus in the treated area, we recommend preventative therapy.**

**x \_ \_ \_ Bleeding:** Pinpoint bleeding is rare but can occur following the treatment of brown spot and spider vein. Should bleeding occur, additional treatment might be necessary.

**Pre-Care and After-Care: I understand pre-care and after-care are entirely in my control.** Failure to follow the provided pre-care and after-care guidelines will increase the chance of complications and adverse side effects and decrease the effectiveness of the Treatment. I acknowledge that I have been (or will be given) detailed oral and printed care instructions. If I have any questions about pre-care or after-care, I can contact the office. I agree to follow all of the pre-care and after-care instructions.

**Skin tissue pathology: Energy directed at skin lesions may** vaporize the lesion. Laboratory examination of the tissue specimen may not be possible. Only clearly benign pigmented lesions can be treated. Check with your doctor for a clearance for the treatment.

**Allergic reactions:** In rare cases, local allergies to tape, preservatives used in cosmetics, or topical preparations have been reported. Systemic reactions (which are more serious) may result from prescription medicines. Allergic reactions may require additional treatment.

**Wear sunscreen of SPF 25 or higher before and after treatment to protect your skin.**

I understand I may need multiple treatments for the desired outcome.

I understand that exposure of my eyes to light could harm my vision. I will keep the eye protection on at all times.

Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, hyper-pigmentation, and hypo-pigmentation.

Occasionally, unforeseen mechanical problems may occur, and your appointment will need to be rescheduled. We will make every effort to notify you before you arrive at the office. Please be understanding if we cause you any inconvenience.

ACKNOWLEDGMENT: My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks.

I, at this moment, release (staff) all estheticians, nurses, technicians, and doctors at this facility and Evergreen Laser (facility) from all liabilities associated with the above-indicated procedure.

My initials above and signature below acknowledge that the above information has been carefully read and fully understood by me and authorizes Evergreen Laser & Med Spa and its employees (collectively and at this moment known as "Evergreen Laser & Med Spa") to perform, implement, and/or assist in the laser treatment procedure For Removal/Reduction of Brown/Age Spots, Rosacea, Acne & Spider Veins I have elected to undergo. I agree that this Informed Consent shall be effective for the first Treatment and for any and all subsequent Treatments I receive in the future. I acknowledge that this form constitutes full disclosure but may be supplemented by other verbal and/or written disclosures that I completed on "today's date," stated on pages one of two on this consent form. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor, or nurse of my current medical or health conditions and update my records. Recent medical history is essential for the caregiver to execute appropriate treatment procedures.

\_\_\_\_\_  
PRINTED NAME OF PATIENT (FIRST, LAST)

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PATIENT SIGNATURE