Fraxel Consent

_____ I understand that I will have to wear protective eyeglasses during the course of the treatment to protect my eyes from the laser light. Occasionally numbing cream may get into the eyes and cause discomfort; we take precautions to try and avoid this from happening.

_____ I understand there are risks and complications that can occur from a laser treatment that can interrupt my daily life, work routine or social life. These may include but are not limited to:cold sore reactivation, acne or crust formation, discomfort, swelling, redness, scarring, infection, hypopigmentation (lighter skin), and hyperpigmentation (darker skin). If any of these were to occur, I understand our physician is available to see me and provide posttreatment guidelines to speed my recovery time. If I choose to consult my own physician or seek any other medical attention it is at my own expense.

_____ For best results, I have been informed that multiple treatments may be needed; because all individuals are different, it is not possible to completely predict who will benefit from the procedure. Some patients will have very noticeable improvement, while others may have little or no improvement. A series of treatments is usually needed for maximum results.

_____ I understand that tanning during the course of my laser treatment is not recommended and can cause serious complications. I understand that this includes sun exposure, use of a tanning bed and self tanners. I understand it is very important to inform the provider if my skin is tan so laser settings can be adjusted or treatment can be delayed if necessary.

_____ I understand that I should avoid direct sun exposure or tanning beds for at least 4-6 weeks before and 3 months after my laser treatment. I have been informed to use a sunblock with an SPF of 30 or higher on the treated area during the course of my laser treatments and to reapply every 60-90 mins.

_____ I understand posttreatment care is very important and I will adhere to all the instructions given to me. Improper care to the treated area may increase the chances of complications. I am aware that unexpected risks or complications may occur and that no guarantees or promises have been made to me concerning the results of the procedure.

_____ I consent to having photographs taken during the course of my treatments to be retained as part of my file. I understand all photographs are the property of Big Sky Dermatology and are kept confidential.

_____ I have read and understand all information presented to me before signing this consent. I have had ample opportunity to ask questions refill guarding laser hair reduction, side effects and aftercare.

_____ I authorized that I am not pregnant or nursing and that I will repeat inform my provider if I become pregnant. I do not have a history of oral cold sores. I understand it is my responsibility to inform a provider of any medical or prescription changes.

_____ I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me. I understand that I have the right to refuse treatment.

_____ I release Big Sky Dermatology, Medical staff, and providers from liability associated with this procedure. I certify that I am competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns.

NOTE: All prices are subject to change without prior notice.

Printed Name _____

Signature_____ Date _____

Clinician Signature_____ Date_____

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