

# Laser Vein & Redness Removal 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
- \_\_\_\_\_ 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: bruising, welting, crust formation, heat rash, 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. I understand results are not guaranteed. This treatment will improve the appearance of unwanted vasculature but not prevent new vasculature from forming.
- \_\_\_\_\_ 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 darker than when I had my last treatment 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 2 weeks 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.
- \_\_\_\_\_ 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 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 regarding my treatment, 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 have informed my provider of my complete medical history (including keloid formation, etc). 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 \_\_\_\_\_

