Dr. R. van Aardt
Cosmetic Medicine

CONSENT FOR LASER / LIGHT ASSISTED TREATMENTS

Date: _____

Name: Date of Birth:

I hereby request laser / light assisted treatments of lesions / areas as discussed with my Service Provider.

____ Spider Veins	____ Rosacea	____ Photo rejuvenation	____ Activated Photo Facial - AK
____ Birth Mark	____ Scar	____ Stretch Marks	____ Facial Telangiectasia
____ Purple Lip Vessel	____ Keloid Scar	____ Port Wine Stain	____ Photo Dynamic Therapy - PDT
____ Age / Liver Spots	____ Acne	____ Multi Dimensional Therapy	____ Peri-Orbital Reticular Blue Veins
____ Hair Removal	____ Tattoo Removal	____ Skin Blemish - **MUST BE PHYSICIAN CONSULTED**	

_____ I agree and consent and authorize that laser / light assisted treatment may be performed by a Certified Service Provider at this Medi- Spa. I understand that Skin Blemishes must be delegated for treatment by an attending physician.

_____ I acknowledge that I have been consulted and informed of the laser / light assisted treatment that was requested and that all my questions have been answered regarding such procedure. I hereby release this Medi-Spa and their Service Providers from any and all liability for any adverse effects that may result from this procedure.

_____ For the purpose of accurate record keeping in connections with the care and treatment which I am receiving and will subsequently receive from this Medi-Spa, I understand that before, during and post treatment close-up photographs be taken of the involved and the anatomical region surrounding the area(s).

_____ I recognize that laser / light assisted treatment is not an exact science and I acknowledge that no guarantees or assurances have been made to me as to a result or cure.

_____ I understand that there are risks related to any laser / light assisted treatments and may include the following:

_____ **Infection:** Albeit rare, skin infection is a possibility any time a skin procedure is performed. I acknowledge and understand that although rare, it is possible for a skin infection to become a blood-borne wide spread infection.

_____ **Allergic reactions:** Although uncommon, I could possibly develop an allergic reaction to medicines applied to the treated area and that I could possibly develop an allergic reaction to any medications that may be prescribed for me.

_____ **Haemorrhage and 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.

_____ **Recurrence of the lesion**: I may not experience permanent results even with multiple treatments.

_____ **Painful or unattractive scarring:** Scarring is a rare complication of laser assisted treatment, but scarring is possible because the skin surface is disrupted by the laser. To minimize the chances of scarring, it is most important that I follow all postoperative instructions carefully.

_____ **Discomfort and pain:** Some discomfort will be experienced during and after the laser/light treatment. I give my permission for the administration of topical and/or local injection of anaesthesia when and if deemed appropriate.

_____ **Pigment changes (skin color):** During the healing process, the treated area may become either lighter or darker in color than the surrounding skin. This is usually temporary, but on a rare occasion, it may be permanent.

_____ **Poor healing:** Any resultant open wound may require more than the usual one to three weeks to heal. Please contact this clinic for medical advice.

_____ **Sun exposure:** Once the surface has healed, it may be pink and sensitive to the sun. Treated areas should be blocked completely, a sun block with a SPF greater than 40 should be used at all times in areas not protected by clothing, whether or not I am in the sun.

_____ **Blindness and eye damage:** The laser/light, without protective eyewear, may cause visual loss including blindness**. It is important to keep these shields on at all times during the procedure** and that I should keep my eyes closed in order to protect my eyes from accidental laser / light exposure.

_____ I understand and acknowledge that I have been informed by means of visual aids, as well as individual discussion, that multiple treatments are often required to cause long-term results and that some patients have no results even with multiple treatments. Normally treatments required is anything from 2-12, depending on the type of laser / light assisted treatment required.

_____ I understand that payment of this treatment is non-refundable and that I will not hold this Medi-Spa or Service Providers responsible if this course of treatment is not to my satisfaction and expectations.

_____ I acknowledge that I have been given an opportunity to ask questions about my condition, ask about alternate forms of treatments, the procedure to be used, and the risks and hazards involved and I believe that I have sufficient information to give an 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 understand and consent that pre- and post-photographs will be taken of the treatment area.

_____ I am a minor under the age of 18 and I understand that the consent of my parental / legal guardian, having legal custody will be required to consent before treatment.

_____	_____	_____
Print Name of Client / Guardian	Signature of Client / Guardian	Date
_____	_____	_____
Print Name of Service Provider	Signature of Service Provider	Date