DR Skin
INTEGRATIVE DERMATOLOGY & LASER SPA
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# FAQS: Halo Fractionated Laser Resurfacing

**Patient Name:**_____ **DOB:**___/___/____

**Procedure(s)**:_____ **Date of Procedure:** ____/_____/_____

**Total Cost Due**:$_____

**What is the procedure used for?**

• Halo is best suited for patients who want to achieve the results of an ablative fractional laser but cannot afford the downtime associated with the standard non-hybrid ablative lasers. Halo combines benefits of non-ablative and ablative laser technologies leading to improvement in fine lines/wrinkles, pigment, pores, and irregular texture with a relatively easy recovery. Patients report that their skin seems to "glow" after treatment. Areas often treated include the face, neck, and chest.

**What changes can I expect right after treatment?**

• Redness, mild swelling, mild crusting

**When will I be completely healed?**

• Average of 5 days to resolve any mild peeling and crusting

**How many treatments are recommended? How far apart?**

• 3-4 Treatments, 1 month apart

**How painful is treatment?**

• Pain: 5-6/10. Pain usually subsides quickly within a few hours. Most patients elect for tylenol taken one hour before treatment, making it well tolerated; but we highly recommend you have a driver to take you home. Anesthetic nerve blocks are sometimes administered by your doctor first to sensitive areas such as around the mouth (dental block).

**How long does the treatment last?**• 1 to 1.5 hours

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**When can I expect to see the <u>full</u> results?**

• 2-3 months after final treatment; many patients note significant improvement after 1 treatment.

_____ (Initials) Your signature at the bottom of this form signifies that you understand that the services and/or supplies identified above may not be considered eligible for benefits (i.e. service may be determined not to be medically necessary, non-covered or investigational) by your health insurance carrier.

_____ (Initials) You will be responsible for payment in full at the conclusion of the visit and fully accept the fact that the charges incurred are out-of-pocket expenses and will not reimbursed by your insurance carrier. This office will at no time, now or in the future, submit a claim to your insurance carrier as the provider has deemed the service to be not medically necessary under the terms of this practice's contract with your carrier.

By signing below, I am acknowledging that I am financially responsible for payment of the full balance at the time of service.

Patients Signature: _____

Date Signed : ___/___/____