3919 W Jefferson Blvd, Suite B
Fort Wayne, IN 46804
Phone - (260)450-1313
Fax - (260)222-2844

FAQS: Fully Ablative Erbium/Contour TRL Laser Resurfacing

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

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

Total Cost Due:$_____

What is the procedure used for?

This is the most aggressive and effective resurfacing offered for moderate to severe wrinkles and texture changes and acne scarring on the face. Especially effective for lines around the eyes and the vertical lines on the upper and lower lips.

What changes can I expect right after treatment?

Swelling, crusting, oozing, discomfort for 4-5 days
Redness, peeling, mild crusting for 8-12 days
Residual pink color changes up to 3-4 months that can be covered by makeup once crusting has resolved. When will I be completely healed?

At 2 weeks makeup can be applied to cover any residual redness. Social engagements not recommended for at least 14 days after treatment.

How many treatments are recommended? How far apart?

1-2 treatments depending on severity of surface wrinkles and texture, spaced 3-4

months apart.

How painful is treatment?

Pain 8/10. Most patients elect for oral pain medicine and anxiolytic (Ativan) taken one hour before treatment – this makes the treatment comfortable for most patients; ***but you must have a driver to take you home***. Nerve blocks are often administered by your doctor to sensitive areas such as around the mouth.

How long does the treatment take?

Expect to be in the office for around 2 hours, but the actual treatment time averages 1 hour for a full face treatment, and shorter if only focal areas are treated like around the mouth.

3919 W Jefferson Blvd, Suite B
Fort Wayne, IN 46804
Phone - (260)450-1313
Fax - (260)222-2844

When can I expect to see the full results?

The full result of collagen building and wrinkle reduction takes 3-4 months.

What is the cost?

Full face is $3500 per treatment; and less for smaller focal areas.

_____ (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 : ___/___/____