



**Reflections ALS**  
**Recommended Pre & Post Care for Pigmented Lesion Treatments**  
*For best results please follow these instructions*

Before your treatment:

- Do not wear makeup on the day of treatment
- No sun-tanning or self-tanners 4 weeks prior to treatment
  - Includes spray tans, tanning lotions, tanning beds, sun exposure, etc.
- Some medications or supplements may increase the risk bruising. Consult with your physician.
- Avoid treatments that may irritate the skin for 1-2 weeks prior to treatment (waxing, depilatories, etc.)
- Notify clinic with any changes to your health history or medications since your last appointment
- History of herpes or cold sores may require an anti-viral prescription prior to treatment

After your treatment:

- Avoid sun exposure and use a broad spectrum (UVA/UVB) sunscreen to prevent further sun damage
  - Bruising, redness and swelling are common and resolve with time
  - Treated pigment will turn darker (brown to black) within 24-48 hours
    - Do not pick at treated areas
    - Treated pigment will exfoliate off the face in approximately 1 week
    - Treated pigment will exfoliate off the body in approximately 2-3 weeks
  - Avoid heat – hot tubs, saunas, etc. for 1-2 days
  - Avoid skin irritants (examples below) a few days post-treatment
    - Products containing tretinoin, retinol, benzoyl peroxide, glycolic/salicylic acids, astringents, etc.
  - Notify clinic of any concerns (blistering, excessive redness/swelling, etc.)
  - Consult with clinic about when to resume skin care regime.
  - Additional instructions: \_\_\_\_\_
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Clinic: \_\_\_\_\_ Reflections ALS \_\_\_\_\_

Clinic Phone Number: \_\_\_\_\_ 772 567-7196 \_\_\_\_\_

PATIENT INFORMED CONSENT FORM TEMPLATE\*  
FOR PICO GENESIS TREATMENT

\*(NOTE: THIS PATIENT INFORMED CONSENT TEMPLATE IS PROVIDED "AS IS" AND IS INTENDED FOR INFORMATIONAL PURPOSES ONLY. THIS TEMPLATE MAY NOT MEET ALL STATE AND FEDERAL LEGAL OR REGULATORY REQUIREMENTS FOR USE WITH PATIENTS. PHYSICIANS USING THIS TEMPLATE ARE RESPONSIBLE FOR ENSURING THE INFORMED CONSENT FORM USED WITH PATIENTS MEETS ALL APPLICABLE STATE AND FEDERAL LEGAL AND REGULATORY REQUIREMENTS, AND ARE ENCOURAGED TO CONSULT WITH THEIR ATTORNEY.)

I hereby authorize Dr. \_\_\_\_\_ or \_\_\_\_\_, under Dr. \_\_\_\_\_'s supervision to perform PICO Genesis Treatment for Skin Revitalization or Melasma treatment on me. I understand that this procedure works to make diffuse or mottled pigment more uniform or for the temporary treatment of Melasma symptoms. I understand that multiple treatments are required and it is possible the result will be minimal or not help at all. Melasma patients should understand that treatment is maintenance of the Melasma symptoms and is not a permanent treatment.

I am aware of the following possible experiences/risks:

- DISCOMFORT – A warming sensation may be experienced during treatment.
- REDNESS/SWELLING/BRUISING – Short term redness (erythema) of the treated area is common and may occur. There also may be some swelling and/or bruising.
- SKIN COLOR CHANGES – During the healing process, there is a possibility that the treated area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- ITCHING/DRY SKIN – Treatment may result in itching and/or dry skin.
- RED RASH/BUMPS – Red rash/bumps may appear after treatment. This resolves with time.
- URTICARIC REACTION – Localized rash with or without redness and/or itching may appear up to 48 hours post-treatment. An anti-histamine can be administered or hydrocortisone can be applied. Symptoms should resolve within a few days.
- WOUNDS – Treatment can result in burning, blistering, or bleeding of the treated areas. If any of these occur, please call our office.
- INFECTION – Infection is a possibility whenever the skin surface is disrupted, although proper wound care should prevent this. If signs of infection develop, such as pain, heat, or surrounding redness, please call our office \_\_ (Phone number) \_\_\_\_\_.
- SCARRING – Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.
- SUN EXPOSURE / TANNING BEDS / ARTIFICIAL TANNING - May increase risk of side effects and adverse events.
- EYE EXPOSURE – Protective eyewear (shields) will be provided to you during the treatment. Failure to wear eye shields during the entire treatment may cause severe and permanent eye damage.

I acknowledge the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me
- Alternative treatments such as topicals, microdermabrasion, or surgery
- Reasonably anticipated health consequences if the procedure is not performed.
- Possible complications/risks involved with the proposed procedure and subsequent healing period

For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep Dr. \_\_\_\_\_ and staff informed should I become pregnant during the course of treatment.

Photographic documentation will be taken. I hereby do \_\_\_ do not \_\_\_ authorize the use of my photographs for teaching purposes.

ACKNOWLEDGMENT

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FOR LASER GENESIS TREATMENT, AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.

\_\_\_\_\_  
Signature-Patient or Guardian

\_\_\_\_\_  
Print Name/Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature-Witness

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date