Skin Rejuvenation Consent

I_________________________________, hereby authorize Dr. George Kamajian or any delegated, qualified, staff member to perform:

I understand and agree that the total cost to me for this procedure is $____________ and that once treatments begin, there are no refunds. I also have read and signed the Financial Policy Form provided to me which explains my financial responsibility for this procedure.

I wish to receive treatment on the following:

	Please Specify Area(s)
___ Laser Wart Reduction	______________________________
___ Laser Nail Fungus Reduction	______________________________
___ Laser Vein Therapy	______________________________
___ Skin Tightening	______________________________
___ IPL	

Please select and initial next to the treatment type you are interested in:

____ I understand that the **Skin Tightening** procedure works by creating a thermal response in the dermis that induces collagen contraction and stimulates new collagen. There is little or no downtime associated with this treatment. It is possible the result will be minimal or not help at all. **Patient Initials _____**

____ I understand that the **Toenail Fungus and Wart Reduction** procedures work on promoting vibrant and healthy looking skin by creating a thermal response in the dermis that stimulates new collagen. I understand the laser machine treats Onychomycosis and wart reduction, but is not yet FDA approved to do so. **Patient Initials _____**

____ I understand that the **IPL** is performed with the Cynosure Icon light based device on me. This procedure treats pigmented lesions, age spots, and sun spots by targeting melanin with a bright pulsed light. I understand I may not experience complete clearance and that it may take multiple treatments. Some conditions may not respond at all and in rare cases may become worse. **Patient Initials _____**

____ I understand that **Vein Therapy** is performed to remove or lighten the appearance of vascular lesions with the Cynosure Icon. The procedure involves using a laser or pulsed light device to coagulate the vessels or vascular lesion. It may take multiple treatments to obtain optimal results and it is possible that the results will be minimal or not help at all. Light based devices will not prevent you from developing new veins. Although these devices are effective in most cases, no guarantees are made. **Patient Initials _____**

Your laser treatment is part of an overall medical and/or cosmetic regimen. Maximum success is based on compliance with all of our recommendations including medication, changes in lifestyle and sun exposure. The final result of any cosmetic procedure is subjective. Aging is a progressive physiologic state. Most treatment programs offered involve set fixed intervals.

By signing below, I acknowledge and understand that the following topics have been discussed with me prior to any procedure being performed:

Potential benefits of the proposed procedure
Probability of success
Reasonably anticipated consequences if the procedure is not performed, if any
Possible Post-Procedure Experiences and Risks and subsequent healing period
Post-treatment instructions
Pregnancy status

- By signing below, I hereby indicate that I am not pregnant.

By initialing, I authorize the use of my photographs for teaching purposes___________

BY SIGNING BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION REGARDING THE PROCEDURE I WISH TO BE PERFORMED AND AFTER CAREFUL CONSIDERATION, I WISH TO PROCEED AT MY OWN RISK. I HEREBY AUTHORIZE DR. GEORGE KAMAJIAN AND OR HIS DESIGNATED STAFF TO PROCEED AS OF THE EFFECTIVE DATE NOTED BELOW WITH ANY AND ALL PROCEDURES AS NECESSARY AND UNTIL TREATMENT IS ARE CEASED AND OR COMPLETED.

Print Patient Name_____________________________________ Patient Signature __________________
Print Staff Name_______________________________________ Staff Signature____________________
Effective Date________/______/______

Pre Treatment Instructions

- Please arrive 15 minutes prior to scheduled appointment for paperwork.
- We will not be able to treat you if you have an active cold sore. It is advised that you pre-medicate one day prior to treatment to prevent any possible breakouts.
- It is required that you do not take antibiotics 3 days prior to and 3 days post treatment. If you are on an antibiotic regimen, please call us at least 24 hours in advance to reschedule.
- Avoid sun exposure, tanning beds, and tanning creams at least 2 weeks prior treatment, or we will not treat you. Instead, use at least an SPF 30 sunscreen.
- Acne patients having used Accutane should have discontinued the use of it for at least 6 months prior to laser treatments.
- Wear loose, comfortable clothing that will not rub the treatment area.
- Please inform our staff before treatment if you have a history of hyper/hypo-pigmentation or inflammation, scarring, or have sensitive skin.

Post Treatment Instructions

- Avoid sun exposure for 1 week after your treatment.
- The treated area may be flaky or appear speckled for a few days.
- Avoid using irritating products like Retin-A, exfoliants, astringents, alcohol, etc. for at least 24 hours if redness or irritation of the skin is observed.
- Apply cold compress to area if it feels hot after your treatment. Aloe Vera 1% Hydrocortisone applied for any irritation can be effective.
- If blistering occurs, apply antibiotic ointment such a Bacitracin and cover with a nonstick bandage until the wound is healed. Call the office **immediately**. Do not rupture or pick at the blisters.

Patient's Initials_____