



Laser/IPL/RF Consent Form

I consent to authorize **GLOW MD** to perform Laser/IPL/RF treatment on me. Light can be used effectively to destroy targets located in the skin with minimum damage to the surrounding tissue. Light is used to lighten, fade or remove photodamaged skin, veins, and/or tattoos in a non-ablative manner. Visible signs of photodamage include wrinkling, enlarged pores, course skin texture, and pigment alterations.

I certify that I do not have any of the following conditions which are CONTRAINDICATIONS to laser treatment: history of melanoma, raised moles, suspicious lesions, keloid scar formation, active infection, open lesions, hives, active herpetic lesions, tattoos or permanent makeup in an area of treatment, use of medications such as Accutane, Tetracycline or St. John's Wort in the last year, autoimmune disease such as lupus, scleroderma, vitiligo or have used sunless tanning products in the last 10 days. I certify that I am not pregnant, trying to get pregnant or nursing.

I have informed my technician of my recent sun exposure and if I have had any, I understand the risk of skin discoloration with treatment.

Photo therapy, despite its high levels of efficacy and safety, is not free of side effects. Erythema (redness) and edema (swelling) of the treated area can occur but usually subsides within a few hours, but can last up to seven days or longer. Irritation, itching, and/or mild burning sensation or pain (similar to a sunburn) may occur within 48 hours of treatment

Pigment changes, such as hyperpigmentation or hypopigmentation, of the skin in the treated areas can occasionally occur. Most often, it is transient, lasting up to six months, but in rare cases can be permanent. Most cases of hyper-or hypo-pigmentation occur in people with darker skin or when the treated area has been exposed to sunlight before or after a treatment. Occasionally, these pigment changes can occur despite appropriate protection from the sun.

Unprotected sun exposure in the weeks following treatments are contraindicated as it may cause pigmentation changes or worsen the condition.

Scarring, which can be hypertrophic or even keloid can occur. Other known complications of this procedure including blisters, reddening, pinpoint pitted scars, bruising, superficial crusting, burns, pain or infection. These side effects are usually temporary, lasting from five to ten days but can be permanent as well.

The skin at or near the treatment site may be fragile. If this happens, makeup should be avoided and the area should not be rubbed, as this might tear the skin. A blue-purple bruise may appear on the treated areas, which might last several days. As the bruise fades, there may be rust-colored brown discoloration of this skin, which typically fades in one to three months.

Even though appropriate measures are taken to reduce side effects, they cannot be completely eliminated in every case. I understand that the treatment may involve risk of complications or injury from both known and unknown cases, and I freely assume all risk. There may be other treatment options, such as injections, or types of laser/light therapy, or chemical peel. With this in mind, I am choosing this non-invasive treatment for vascular and/or pigment lesions and/or tattoo removal and other indicated skin conditions.

Eye damage can occur from the light and therefore protective eyewear must be worn during all phototherapy sessions.

I have read and understand the Pre- and Post- treatment instructions. I agree to follow these instructions carefully. I understand the compliance with recommended pre and post procedure guidelines are crucial for healing prevention of scarring, and other side effects and complications, such as Hyperpigmentation, hypopigmentation, and other textural changes.

I understand that this treatment is not meant to replace the necessity for a complete dermatologist examination.

No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. I am aware that follow-up treatments may be necessary for desired results. Most clients require a number of treatments over several months with gradual results occurring over this time. I agree to adhere to all safety precautions and regulations during this treatment. No refunds will be given for treatment received.

The nature and purpose of the treatment has been explained to me. I have read and understand this agreement. All of my questions are answered to my satisfaction, and I consent to the terms of this agreement. Alternative methods of treatment and their risk and benefits have been explained to me and I understand that I have the right to refuse treatment.

I release **GLOW MD**, staff, and specific technicians from liability associated with this procedure. I certify that I am competent adult of at least 18 years of age.

Patient Name: _____

Patient Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____