dM cosmetic & wellness centre

LIGHT-BASED TREATMENT CONSENT FORM

PLEASE INITIAL EACH PARAGRAPH AND SIGN BELOW

Initial HERE

_____ I authorize DM Cosmetic and Wellness Centre, Dr. Matta and/or Dr. I. Matta Medicine PC and any designated employee to use laser and/or IPL to reduce pigmented or vascular lesions and/or unwanted hair. I understand the procedure is purely elective, the results vary with each individual and that multiple treatments may be necessary.

_____ Intense light can cause eye injury; I will wear protective eyewear to prevent eye damage.

_____ I understand the treatment of benign pigmented and vascular lesions may not be successfully accomplished without possibly producing some epidermal damage that may take 2 or more weeks to resolve.

_____ I understand that sun exposure or use of tanning lamps or self tanning creams and not adhering to the post-care instructions provided to me, will increase my chance of complications including hyperpigmentation.

_____ I have not exposed the treatment area to the sun /tanning lamps or self tanning creams for the last 6 weeks.

_____ I understand the importance of having an accurate diagnosis by a physician of brown spots prior to treatment, as treatment of an undiagnosed skin cancer may delay proper medical care.

_____ **I consent to photographs being taken to evaluate treatment effectiveness, for medical education, training, professional publications or sales purposes. No photographs revealing my identity will be used without my written consent. If my identity is not revealed, these photographs may be used and displayed publicly without my permission.**

_____ I understand that: serious complications are rare, but possible. Common side effects include temporary redness and mild "sunburn" like effects that may last a few hours to 3 – 4 days or longer.

_____ The sensation of light is sometimes uncomfortable and may feel like a moderate to severe pinprick or burst of heat. Pigment changes (light or dark spots on the skin) lasting 1 – 6 months or longer may occur.

_____ Freckles may lighten and/or temporarily or permanently disappear in treated areas. There is the likelihood of coincidental hair removal when treating pigmented/vascular lesions in hair bearing areas.

_____ Other potential risks include crusting, itching, pain, bruising, skin whitening, burns, blisters, infection, scabbing, scarring, swelling and failure to achieve the desired result.

_____ I understand that light treatment can trigger a herpes outbreak and agree to taking medication before and after the procedure.

_____ I am not pregnant.

_____	_____	_____	_____
Please Print Full Name Legibly	Patient Signature	Today's Date: DD/MM/YYYY	Dr. Matta

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For Laser Hair Removal

Initial HERE

_____ I understand that treatment of facial hair may result in a worsening of the hair growth.

_____ I understand that thin hairs may become thicker and darker.

_____ I understand that laser hair removal is most effective for terminal hairs as opposed to vellous hairs.

_____ I understand that even with multiple treatments (ie more than 20) the facial hair may still not ---- Improve or even get worse.

_____ I have had the opportunity to ask any questions that I have and request that I receive this treatment.

_____ I understand that complete clearing may not be possible and will depend upon the type, age and color of the lesion. Multiple treatments may be needed for the best results.

_____ I understand that flatulence during perianal treatments can cause potential burns and/or small fires.

_____ I understand that any treatment provided may or may not meet my expectations. I understand and agree that there is no compensation or refund of monies paid in any event.

_____ I have been given the opportunity to ask questions about the procedure. My questions have been answered and I understand the information given to me.

_____ Contraindications to the performance of this procedure have been discussed in detail with me.

_____ I recognize that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me concerning the results of such procedures.

_____ I have read and understood all information presented to me before signing this consent form.

_____ Before and after treatment instructions have been discussed with me and not adhering to these instructions provided to me may increase my chance of complications. The procedure as well as the potential benefits and risks have been explained to my satisfaction. I have also been given the opportunity to ask questions, and have all my questions answered. I freely consent to the proposed treatment. I have read and understand all information presented to me before consenting to this treatment.

_____	_____	_____	_____
Please Print Full Name Legibly	Patient Signature	Today's Date: DD/MM/YYYY	Dr. Matta