



Patient Consent Form – GentleMax

I authorize (healthcare professional's name) _____ to perform Laser treatments on _____ (patient's name) with the _____ GentleMax, to treat my condition, which is called: _____.

The Laser is a device that produces an intense but gentle burst of light. This light is absorbed by and causes selective heating of certain cells in your unwanted lesion. Lesions most commonly fade slowly over time as normal body processes eliminate these destroyed cells. This laser is used for Hair Reduction, Leg Vein Reduction, and Skin Tightening.

My eyes will be covered with laser specific safety eyewear or an opaque material to protect them from the intense light. My eyes will be closed and I will not attempt to remove the eye protection during treatment.

I have been informed of the following possible risks and complications of this procedure including but not limited to:

Purpura (red-purple discoloration, bruising)

Itching (hive-like response which lasts 2-3 hours to 2-3 days)

Herpes simplex virus activation

Burns, blisters, scabbing, crusting, skin color and /or textural changes

Hyperpigmentation (darkening of the skin; transient or long term))

Hypopigmentation (lightening of the skin; transient, long term or possibly permanent)

Scarring (rare, possibly permanent)

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.

Other methods of treating this condition have been discussed with me such that I may assess the risks and benefits of these alternative treatment methods.

My provider or I may elect to use a form of topical anesthesia to reduce any discomfort during the procedure. A cryogen spray skin-cooling device may be used during the procedure to decrease discomfort and protect the skin. All anesthesia options and risks will be discussed with me in advance. I understand that immediately following the laser treatment redness; swelling, discomfort, bruising, and discoloration may develop at the treatment site. I understand that any discoloration may last 7-14 days



and swelling should resolve within several days. Discomfort may be treated with the application of cool compresses or topical soothing agents.

I will be given complete instructions regarding after care of the treated area .It is important to follow after care instructions carefully to minimize the chance of incomplete healing, skin textural changes or scarring. Sun avoidance and /or use of a sunblock may be recommended. Tanning should be avoided.

____ I have provided my past and current medical history and medications.

____ I consent to the taking of photographs during the course of my laser therapy for healthcare records.

____ I consent to using my photographs for medical education and /or marketing purposes.
My name will not be used to identify these photographs.

____ I am not pregnant (female patients).

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.

Signed: _____ Date: _____

Witness: _____ Time: _____