Donna Johnston, MD: Consent for Laser/Light-Based Treatment

Patient name: _____ Date: _____

I authorize Donna Johnston, MD/Kristen Laurella, ARNP, to perform laser/pulsed light cosmetic skin treatments on me, including, but not limited to, the treatment of pigmented lesions (for example, sun spots, age spots, and other skin discolorations), vascular lesions (for example, red spots, leg veins and small spider veins, but not varicose veins), wrinkles, (rhytides), furrows, fine lines, textural irregularities, nonablative skin resurfacing, soft tissue coagulation, reducing or eliminating hair. I understand that the procedure is purely elective, that the results may vary with each individual, and multiple treatments may be necessary.

I understand that:

- The Icon Aesthetic System is a pulsed-light and laser system that delivers a precise impulse of light energy that is absorbed by a chromophore in skin, for example, hemoglobin in the blood or pigment in a lesion, causing a thermal reaction. All personnel in the treatment room, including me, must wear protective eyewear to prevent eye damage from this light energy.
- The sensation of light is sometimes uncomfortable and may feel like a moderate to severe pinprick or flash of heat. Anesthesia or sedation (calming medication) may be advisable for laser skin resurfacing treatments. If the practitioner or physician elects to use an anesthetic to reduce discomfort during any light-based treatment, all options and risks associated with the anesthetic will be discussed with me.
- The treated area may be red and swollen for two to twenty-four (2-24) hours or longer. Cooling the area after the treatment (for example ice packs, topical gels) may help reduce discomfort and swelling.
- Common side effects include temporary redness or mild “sunburn”-like effect that may last a few hours to 3-4 days or longer. Other potential side effects include, but are not limited to, crusting, irritation, itching, pain, burns, scabbing, swelling, broken capillaries, bronzing, and acne or herpetic outbreaks. There also is a risk of resulting unsatisfactory appearance and failure to achieve the desired result.
- Pigment changes, including hypopigmentation (lightening of the skin) or hyperpigmentation (darkening of the skin), lasting one to six (1-6) months or longer or permanently may occur. Freckles may temporarily or permanently disappear in treated areas.
- Serious complications are rare but possible, such as, scarring, blood clots, skin loss, hematomas (collection of blood under the skin), and allergic reaction to medications or materials used during the procedure.
- I understand and accept that with skin resurfacing treatments, there may be an increased length of social downtime associated with the level of treatment. There also is a chance of additional side effects like blanching and significant redness.
- There is not guarantee that the expected or anticipated results will be achieved.
- Sun, tanning bed, or tanning lamp exposure, the use of self-tanning creams, and not adhering to the post-treatment instructions provided to me may increase my chance of complications. I must avoid the sun, tanning beds, and sunless tanning lotions and use sunblock (SPF 45 or higher recommended)after treatment.

- There is a possibility of coincidental hair removal when treating pigmented or vascular lesions in hair-bearing areas. There is a risk that the hair regrowth may be changed, such as little to no regrowth or more regrowth than before.
- I should call my provider as soon as possible if I have any concerns about side effects or complications after treatment.
- I hereby consent to the administration of any anesthesia or sedation considered necessary or advisable for my procedure. I understand that all forms of anesthesia and sedation involve risk and the possibility of complications, injury, and in rare instances death.
- Not providing my medical history before proceeding with a light-based treatment could impact treatment results and cause complications.

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

Before and after-treatment instructions have been discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction.

I have read and understand all information presented to me before consenting to treatment. I have had all my questions answered.

I freely consent to the proposed treatment today as well as for future treatments as needed.

Signature:_____ Date:_____

Print name:_____

Witness signature:_____ Date:_____

Print name:_____

Physician/provider signature: _____ Date:_____