BRONSON	Affix Patient Label
	Patient Name: DOB:

Informed Consent Fractional Non-Ablative Laser Treatment for Wrinkle and Scar Reduction

This information is given to you so that you can make an informed decision about having **Fractional Non-Ablative Laser Treatment for Wrinkle and Scar Reduction.**

Reason and Purpose of the Procedure:

Fractional non-ablative lasers deliver heat deep into the skin to treat wrinkles and age related blemishes. It tightens the skin and stimulates collagen growth. Surrounding tissue is unchanged. Healthy tighter skin grows to replace wrinkled skin. Multiple sessions may be needed to achieve complete satisfaction.

A numbing cream will be applied before treatment to reduce discomfort.

Benefits of this procedure:

You might receive the following benefits. Your provider cannot promise you will receive any of these benefits. Only you can decide if the benefits are worth the risk.

- Possible reduction of fine wrinkles, scars and stretch marks
- Decrease in or removal of pigmented lesions like sun spots or uneven skin color.

Risks of this procedure:

No procedure is completely risk free. Some risks are well known. There may be risks not included in the list that your doctor cannot expect.

- **Redness:** This can last for 1 – 6 weeks.
- **Stinging or heat sensation**: This is usually temporary.
- **Temporary sensitivity to hot or cold.**
- **Temporary pain**
- **Temporary burning or sunburn like feeling.**
- **Blistering:** you may need a topical antibiotic.
- **Temporary Folliculitis:** (inflammation of hair follicle rash)
- **Permanent hair removal.**
- **Crusting:** This is temporary. Do not pick.
- **Itching:** You can use over the counter cortisone cream.
- **Decrease or increase in skin pigment:** This can be permanent.
- **Infection at the treatment site:** You may need antibiotics.
- **Scabbing:** Do not pick at this. Keep it clean and dry.
- **Scarring:** this can be permanent
- **Temporary swelling**
- **Cold sores in the treatment area:** Prophylactic (preventative) treatment with Valtrex® is available if you have a history of cold sores.
- **Failure to get the desired results.**

Risks associated with smoking:

Smoking is linked to an increased risk of infections. It can decrease healing in skin tissue. It can also lead to heart and lung complications and clot formation.

Risks associated with obesity:

Obesity is linked to an increased risk of infections. It can also lead to heart and lung complications and clot formation.

Risks specific to you:

_____

_____

_____

_____

Alternative Treatments:

Other choices:

- Do nothing. You can decide not to have the procedure
- Microneedling
- Chemical peels

General Information:

You should not be pregnant or trying to become pregnant during this procedure.

You should not have this treatment if you have a history of Polycystic Ovarian Syndrome.

You should not be in the sun without protection, use tanning creams or use a tanning bed for three weeks before or during the course of this treatment.

Students, technical sales people and other staff may be present during the procedure. They will be supervised.

Pictures and videos may be done during the procedure. These may be added to my medical record.

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By signing this form I agree:

- I have read this form or had it explained to me in words I can understand.
- I understand its contents.
- I have had time to speak with the Cosmetic Skin Care Registered Nurse, Medical Assistant or Aesthetician. My questions have been answered.
- I want to have this procedure: **Fractional Non-Ablative Laser Treatment for Wrinkle and Scar Reduction**
- I understand that other staff may help with the procedure. The tasks will be based on their skill level.

Patient Signature_____Date:_____Time:_____

Relationship: ☐Patient/Parent of minor ☐Closest relative (relationship) ☐Guardian/POA Healthcare

Interpreter's Statement: I have translated this consent form and the doctor's explanation to the patient, a parent, closest relative or legal guardian.

Interpreter: _____Date_____Time_____

Interpreter (if applicable)

For Provider Use ONLY:

I have explained the nature, purpose, risks, benefits, possible consequences of non-treatment, alternative options, and possibility of complications and side effects of the intended intervention. I have answered questions, and the patient has agreed to procedure.

Provider/Cosmetic Skin Care RN/MA/Aesthetician
Signature: _____ Date: _____ Time: _____

Teach Back

Patient shows understanding by stating in his or her own words:

____ Reason(s) for the treatment/procedure: _____
____ Area(s) of the body that will be affected: _____
____ Benefit(s) of the procedure: _____
____ Risk(s) of the procedure: _____
____ Alternative(s) to the procedure: _____

OR

____ Patient elects not to proceed: _____ Date: _____ Time: _____
(Patient signature)

Validated/Witness: _____ Date: _____ Time: _____