BRONSON	Affix Patient Label
	Patient Name: DOB:

Informed Consent Intense Pulsed Light Treatment

This information is given to you so that you can make an informed decision about having **IPL/Intense Pulsed Light Treatment.**

Reason and Purpose of the Procedure:

Intense Pulsed Light delivers a pulse of light energy that is absorbed by the blood or pigment in a lesion. It can be used to remove hair, reduce dark spots on the skin, reduce redness and reduce the look of facial veins. Multiple treatments may be needed to achieve complete satisfaction.

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.

- Reduction or elimination of hair
- Reduction of dark spots on skin
- Reduction of blood vessels on the face, neck and trunk
- Decrease in flushing or redness caused by rosacea
- Decrease effects of sun damage

Risks of Procedure:

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

Risks of procedure:

- Temporary redness, swelling and mild sunburn like sensation that can last up to 10 days; Cooling the area with ice packs or topical gels may help reduce discomfort and swelling.
- Skin color changes including lightening of skin, darkening of skin and loss of freckles; this can be permanent.
- Temporary redness, itching, irritation, crusting, pain, burns, blisters, scabbing, swelling, acne or cold sores
- Folliculitis (swelling of skin around hair follicle, ingrown hair)
- Reaction to optional topical numbing cream can occur.

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.

General Information

- **You should not be pregnant or trying to become pregnant during this procedure.**
- **This procedure cannot be done if you are currently breast feeding.**
- **You should not have this treatment if you have a history of Polycystic Ovarian Syndrome.**
- **You should not be in the sun without using sunscreen, use tanning creams or a tanning bed for 4 weeks before or during the course of this treatment.**
- **No waxing or plucking for 4 weeks before hair removal**
- **Treatments cannot be done over a tattoo**

Students, technical sales people and other staff may be present during the procedure. My provider will supervise them.

Pictures and videos may be done during the procedure. These may be added to my medical record. These may be published for teaching purposes. My identity will be protected.

BRONSON	Affix Patient Label
	Patient Name: DOB:

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: **Intense Pulsed Light**

I understand that other staff may help with this procedure. Their 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: _____