



Heather J. Roberts, M.D.
A Medical Corporation

Dermatology & Dermatologic Surgery
 Cosmetic & Laser Surgery

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CONSENT FOR BLU-U LIGHT TREATMENT

I, _____, authorize Heather J. Roberts, M.D. or _____ M.D. to perform BLU-U treatments on my FACE / SCALP / HANDS / CHEST / BACK / _____(circle).

WHAT IS BLU-U?

The BLU-U is a cool visible blue light – not a laser which offers effective, non-invasive, pain-free improvement in acne and other acne like skin conditions. The BLU-U kills P. acnes, the bacteria primarily responsible for acne. With BLU-U acne treatments, patients have another option to treat their acne without the side effects of oral medications. Some patients may even be able to decrease the use of topical acne medications.

BLU-U treatments maybe performed as often as 1 - 3 times a week initially depending on your particular needs. Your response to treatment will guide the frequency of additional sessions. Each treatment lasts about 15 minutes.

I understand that I will wear protective goggles during treatment for 15 minutes. A light "acetone scrub" may be performed to remove surface oil and skin cells temporarily before treatment.

Anticipated side effects of BLU-U treatment include: minimal temporary redness.

I understand that I may require 2 - 3 treatments per week for 4 – 6 weeks to achieve optimal results. Initial_____

I understand that there is a small incidence of reactivation of Herpes Simplex virus or "cold sores" in patients with a prior history. I agree to inform Dr. Roberts or _____ M.D. of any such history prior to my procedure so antiviral medication may be prescribed. Initial_____

To my knowledge, I am not currently pregnant. Initial _____

I understand that medicine is not an exact science and that there can be no guarantees regarding my results. I am aware that these treatments may not work for me. I understand that alternative treatments include topical acne medications, oral medications, like antibiotics, birth control pills or Accutane, chemical peels and doing nothing.

I realize this procedure is considered "cosmetic" and that I am responsible for payment in full at the time of the procedure. Initial_____

By my signature below, I acknowledge that I have read the "Consent for BLU-U Light Treatment" in it's entirety and understand it. I have been given the opportunity to ask all my questions. All my questions have been answered fully to my satisfaction. I have been adequately informed of the risks, benefits and alternatives of this treatment and wish to proceed.

Patient Signature_____ Date_____

Guardian Signature(if patient is a minor)_____

Relationship to patient_____

Witness Signature_____ Date_____