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

Dermatology & Dermatologic Surgery
Cosmetic & Laser Surgery

Diplomate, American Board of Dermatology
Fellow, American Academy of Dermatology
American Society of Dermatologic Surgery
California Dermatology Society
The American Society for Laser Medicine and Surgery
Skin Cancer Foundation
Clinical Associate Professor of Dermatology, USC Keck School of Medicine

INFORMED CONSENT FOR OMNILIGHT LASER TREATMENT

I, _________________________, hereby give my consent to and authorize Dr. Roberts or ________________ M.D. to perform Omnilight laser removal of blood vessels/ acne/ brown spots / wrinkles / scars on my _________________________.
(cirlcle all that apply)

The Omnilight is a light source that produces an intense but gentle burst of light that treats acne, scars, pigment and abnormal blood vessels without harming the surrounding tissue. To protect my eyes from the intense light, I will have my eyes covered with an opaque material or wear laser protective glasses.

Other methods of treating this type of lesion include: 1) Sclerotherapy for leg veins and using an electric needle for other vascular lesions 2) Chemical peels, cryotherapy and bleaching agents for brown spots 3) Medical therapy for acne 4) Deep chemical peels, deep laser peels, injection of fillers or cortisone for wrinkles and scars, respectively. The risks, benefits and alternatives of these other therapies have been explained to me.

The possible complications include, but are not limited to:

1. Incomplete removal of blood vessels, brown spots, acne, scars or wrinkles necessitating further treatment. _______(initial)

2. Redness, swelling, bruising, blistering, scab formation, or open sores. If proper wound care is not performed, individual results may vary. _______(initial)

3. Rare occurrence of permanent scars which may be raised, depressed, whiter than my natural skin color or darker than my natural skin color. These risks may be reduced by carefully following my aftercare instructions and by notifying the office if a problem develops. _______(initial)

I understand the effect and nature of the procedure to be performed, the foreseeable risks involved, as discussed by Dr. Roberts or ____________________ M.D., as well as, what I can expect or experience if recovery is uneventful. The goal and purpose of this procedure is to remove blood vessels, wrinkles, scars, acne, brown spots or other selected lesions through 1 or multiple treatments depending on my individual response to treatment.

When Omnilight laser treatments are performed, the skin may be red and swollen for 1-2 days. Any brown spots on the skin will become darker and then come off on their own as I wash my face. The entire healing period usually lasts for 5-10 days, although it can last longer. If strict adherence to proper wound care as explained to me by Dr. Roberts is followed, this may further improve my final results. If faster removal of brown spots is desired, microdermabrasion may be performed 5 – 7 days after Omnilight.
________(initial)

11600 Wilshire Boulevard, #408 • Los Angeles, California 90025 • (310) 477-4727 phone • (310) 477-2001 fax • www.drheatherroberts.com

INFORMED CONSENT FOR OMNILIGHT LASER TREATMENT (continued)

I have been advised that exposure to the sun and excess heat (i.e. saunas, Jacuzzi tubs, etc.) should be avoided at all costs for a period of approximately 4-6 weeks. No sun bathing is permitted during this period. To do so would encourage lightening or darkening of skin color as well as recurrence of blood vessels requiring further treatment. When going outdoors, a good sunscreen and protective hat is strongly recommended.
_______(initial)

I understand that there is a small incidence of the reactivation of Herpes Simplex virus or "cold sores" in patients with a prior history. I agree to inform Dr. Roberts of any such history prior to my laser procedure so antiviral treatment may be prescribed. _______(initial)

I acknowledge that depending on the size and color of the lesion being treated, complete clearing may not be possible or take multiple treatments for best results. _______(initial)

I understand this procedure is considered cosmetic and will not be covered by my health insurance. This office will not bill my insurance for this treatment. My insurance may or may not cover treatment if any complications should arise. _______(initial)

I have discussed my proposed Omnilight laser treatment in detail with Dr. Roberts. I understand that all photographs I have seen are for illustration only and do not guarantee or predict the result I can expect. I have been asked at this time if I have any questions about this procedure. I understand that no guarantee or promises have been made as to the expected results or outcome.

My signature certifies that I have thoroughly read and understand all of the above material, and that I understand the goals, limitations, and possible complications of Omnilight laser treatments of blood vessels, wrinkles, brown spots, scars or acne lesions, and that I wish to proceed with the procedure.

Patient Signature____ Date _______________
Guardian Signature(if patient is a minor)_________________________________
Relationship to patient_____________________________
Witness Signature____ Date_______________