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A Medical Corporation

Dermatology & Dermatologic Surgery
Cosmetic & Laser Surgery

Diplomate, American Board of Dermatology
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American Society of Dermatologic Surgery
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The American Society for Laser Medicine and Surgery
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Clinical Associate Professor of Dermatology, USC Keck School of Medicine

INFORMED CONSENT FOR VBEAM PERFECTA LASER TREATMENT

I, _________________________, hereby give my consent to Dr. Roberts to perform laser removal of blood vessels / blood vessel growths / wrinkles / scars/ brown spots / acne /______________
(cirlcle all that apply)
on my ________________________.

The Candela Vbeam Perfecta is a laser that produces an intense but gentle burst of light that treats unwanted blood vessels, blood vessel growths, redness, brown spots and acne selectively in the skin. 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 these type of lesions include Sclerotherapy for leg veins, an electric needle for other vascular lesions, freezing of brown spots with liquid nitrogen, chemical peels or mircrodermabrasion for brown spots, other types of lasers, medications and/or photodynamic therapy for acne. 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, blood vessel growths, brown spots, acne, warts, 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, darker than my natural skin color, pink or red. These risks may be reduced by carefully following my aftercare instructions and by notifying the office immediately 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 ____________________, as well as, what I can expect to 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.

INFORMED CONSENT FOR VBEAM PERFECTA LASER TREATMENT (continued)

When laser removal of blood vessels, brown spots, acne, wrinkles, scars or vascular growths is carried out, the procedure will cause some redness and swelling which will fade over 1-2 days. The skin may even bruise or form scabs before it heals. Brown spots will gradually get darker until they fall off. The healing period usually lasts 2-7 days, although it can last longer. If strict adherence to proper wound care as explained to me by Dr. Roberts or ____________________ is followed, this may further improve my final results. ________(initial)

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

Following treatment of broken capillaries, rosacea and other blood vessel growths, I have been advised to avoid excessive heat (i.e saunas, hot tubs) for 4–6 weeks. Failure to do so, may encourage the return of blood vessels which will require additional laser treatments

_______(initial)

I understand that there is a small incidence of the reactivation of Herpes Simplex virus or "cold sores" in patients with prior history. I agree to inform Dr. Roberts or ______________________ of any such history **prior** to my laser procedure so antiviral medication 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 VBeam Perfecta laser treatment in detail with Dr. Roberts or ____________________. 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 VBeam Perfecta laser treatment of blood vessels, blood vessel growths, wrinkles brown spots, acne or scars, 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______________