

Informed Consent for CoolTouch Thermescent Laser

Division of Plastic Surgery
University Surgical Associates
Dr. R. Michael Johnson

Procedure date _____ .

I hereby authorize _____ and whoever may be delegated to perform the following procedure: _____

To the Patient

You have the right to be informed about your skin condition and its treatment so, you may make the decision whether or not to undergo the procedure, after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent for treatment.

While CoolTouch Laser is effective in most cases, no guarantee can be made that a specific patient will benefit from the procedure. Additionally, the nature of the laser procedure may require a patient to return for other visits in order to achieve the desired results. I understand that any additional treatments will be the patient's financial responsibility should they be necessary in the future.

I acknowledge that, while the goal of such a procedure is the reduction of wrinkles, the realistic results average between fifty and seventy-five percent improvement. No specific guarantees can or have been made concerning the expected results. Some patients are greatly improved and in others minimal improvement is noticed. I also understand that there is a risk of permanent skin pigment change in some individuals and that scar formation occasionally may develop following such a procedure.

I, as the patient, agree to follow the recommended course of treatment as suggested by the doctor including treatments of glycolic peels and/or microderm abrasion as suggested by a licensed esthetician. Also, to maximize my results by agreeing to follow a skin care regimen set by the esthetician and doctor.

The following points have been discussed with me:

1. The possible benefits of the proposed procedure.
2. The possible alternative medical procedures, such as chemical peels, topical creams, microdermabrasion, Botox injections, or any combination of the above or no treatment at all.
3. The probability of success.
4. The reasonably anticipated consequences if the procedure is not performed.
5. The most likely possible complications/risks involved with the proposed procedure, subsequent healing period; including but not limited to edema, blistering, infection and scarring.

I am aware that I may experience the following with this laser treatment:

Discomfort

Some discomfort may be experienced during the treatment.

Wound Healing

Laser surgery may result in swelling or flaking of treated area, which may require medication to heal. Once the surface has healed, it may be pink and sensitive to the sun for an additional four months.

Bruising, Swelling, Infection

Bruising of treated area may occur. Additionally there may be some swelling noted.

Pigment Change (skin color)

During the healing process, there is a possibility of the treatment area becoming either lighter or darker in color than the surrounding skin. This is usually temporary, but on rare occasions, it may be permanent.

Scarring

Scarring is a rare occurrence.

Eye Exposure

Protective eyewear will be provided. It is important to keep these goggles on at all times during the treatment in order to protect your eyes from accidental laser exposure.

I acknowledge my obligation to follow the instructions and treatment plan closely and visit the office as directed.

I certify that I have read the above consent and I fully understand it. I have been given ample opportunity for discussion and all my questions have been answered to my satisfaction. I have received no medication before signing this consent.

Patient signature

Date

Witness signature

Date