Consent for Laser/Light Treatment

I authorize Arnot Health Aesthetics and MediSpa to perform laser/pulsed light treatments on me, including but not limited to skin resurfacing, reducing or eliminating hair, treatment of pigmented lesions (sun spots, age spots, etc.), vascular lesions, scars, and wrinkles. I understand that the procedure is purely elective, that the results may vary with each individual, and multiple treatments may be necessary.

I understand that:
- There is no guarantee that the expected or anticipated results will be achieved.
- The StarLux system delivers a precise pulse of light energy that is absorbed in the skin, causing a thermal reaction. All personnel in the treatment room, including me, will wear protective eyewear to prevent eye damage from this intense light energy.
- The sensation of light may feel like a pinprick or flash of heat. If the practitioner or physician elects to use a local anesthetic, all options will be discussed with me.
- Common side effects include temporary redness and mild “sunburn” like effects that may last a few hours to 3-4 days or longer. Other potential risks include, but are not limited to, irritation, itching, pain, bruising, scabbing, scarring, swelling, and failure to achieve desired results.
- Pigment changes may last 1-6 months or longer or be permanent. Freckles may temporarily or permanently disappear in treated areas.
- There is a possibility of coincidental hair removal when treating pigmented or vascular lesions.
- There is a potential risk of allergic reaction to any gels, lotions or the numbing anesthetic that may be applied to the skin before treatment. Such risks include temporary swelling, itching, and formation of a rash.
- I understand that sun or tanning lamp exposure, the use of self-tanning creams, and not adhering to the after treatment instructions provided to me might increase my chances of complications.

I consent to photographs and digital images being taken to evaluate treatment effectiveness, for medical education, training, professional publications or sales purposes. No photographs revealing my identity will be used without my written consent.

Before and after treatment instructions have been discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction.

I have read and understand all information presented to me before consenting to treatment. I have had all my questions answered.

I freely consent to the proposed treatment.

Patient Signature:______________________________________________________
Date:____________________________   Time:_____________________________