totally feet pc
podiatry and laser center

Informed Consent for Laser Treatment of Warts

I hereby authorize Dr. Oehler or Totally Feet Staff, under Dr. Oehler's supervision to treat my wart(s) using a laser device. I understand that multiple treatments may be required and it is possible the result will be minimal or may not help at all.

The procedure may result in the following adverse experiences or risks:

DISCOMFORT – Some discomfort may be experienced during treatment.

REDNESS/SWELLING/BRUISING – Short term redness (erythema) or swelling (edema) of the treated area is common and may occur. There also may be some bruising.

SKIN COLOR CHANGES – During the healing process, there is a possibility that the treated area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.

WOUNDS – Deep tissue injury and prolonged wound healing may occur. Treatment can result in burning, blistering, or bleeding of the treated areas. If any of these occur, please call our office.

INFECTION – Infection is a possibility whenever the skin surface is disrupted, though proper wound care should prevent this. If signs of infection develop, such as pain, heat or surrounding redness, please call our Totally Feet P.C. at 720.980.3668.

SCARRING – Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.

EYE EXPOSURE – Protective eyewear (shields) will be provided to you during the treatment. Failure to wear eye shields during the entire treatment may cause severe and permanent eye damage.

I acknowledge the following points have been discussed with me:

- Potential benefits of the treatment of warts, including the possibility that the procedure may not work for me.
- Alternative treatments such as topical or oral medications or even surgery
- Reasonably anticipated health consequences if the procedure is not performed
- Possible complications/risks involved with the proposed procedure and subsequent healing period
- For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep Dr. Oehler and staff informed should I become pregnant during the course of treatment.
- I understand that photographs and videos of my feet and/or legs and procedures done to my feet and and/or legs may be taken and used for teaching purposes, research, publications, and promotional materials. Photographs and videos used will in no way be associated with my name or any other identifiable information. I will remain anonymous from these images and videos and procedures.

ACKNOWLEDGMENT

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FORM FOR TREATMENT OF WARTS, AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.

Signature-Patient or Guardian	**Print Name/Relationship**	**Date**
Signature-Witness	**Print Name**	**Date**