Informed Consent for Laser Skin Rejuvenation and or Scar Reduction

I hereby authorize Dr. Oehler or Dr. Oehler's staff, under Dr. Oehler's supervision to perform Laser Genesis Non-Ablative Skin Therapy on me. I understand that this procedure works on promoting vibrant and healthy looking skin by creating a thermal response in the dermis that stimulates new collagen. I understand that multiple treatments are required and it is possible the result will be minimal or not help at all.

I am aware of the following possible experiences/risks:

DISCOMFORT – A slight warming sensation 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 the treated area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on rare occasion, it may be permanent.

WOUNDS – Treatment can result in burning, blistering, or bleeding of the treated areas. If any of these occur, please call our office.

I**NFECTION** – Infection is a possibility whenever the skin surface is disrupted, although proper wound care should prevent this. If signs of infection develop, such as pain, heat, or surrounding redness, please call our office __(Phone number)_____.

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 proposed procedure, including the possibility that the procedure may not work for me
- Alternative treatments such as topicals, microdermabrasion, or 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 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 FOR LASER GENESIS TREATMENT, 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**