**Dermatology Associates of the South Bay**

**Amber Kyle M.D. and Associates**

LASER & LIGHTBASED TREATMENT CONSENT - IPL, ND: YAG, PDL

**PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_\_\_\_**

I hereby authorize and direct Amber Kyle M.D. and her designated associates or assistants to perform Pulse Dye Laser (PDL), YAG Laser, Multiplex (PDL + YAG), and or Intense Pulsed Light (IPL) treatments on me for treatment of red and or brown pigmentation, vascularity and spider veins, raised or pigmented scars, non-malignant lesions or birthmarks and other skin conditions that have been discussed with me that may be improved through treatment with these devices including but not limited to acne vulgaris, psoriasis, warts, and rosacea. I understand that multiple treatments are usually necessary to achieve desired results and that there is a possibility of only achieving little or even no noticeable improvement. I understand that this is a cosmetic correction and the underlying causes of the pigmentation, vascularity, scars or lesions is not being treated or removed; over time some pigmented or vascular areas may reappear and require retreatment. I also understand some people may not experience any improvement in the treated area or the degree of improvement achieved may be only minimal and that the pigmentation, vascularity, scar or lesion will still be visible following treatment.

The following points have been discussed with me:

* The potential benefits of the proposed procedure.
* The possible alternative procedures.
* The probability of success.
* The reasonably anticipated consequences if the procedure is not performed.
* The most likely possible complications/risks involved with the proposed procedure and subsequent healing period, including, but not limited to: discomfort, itching, infection, swelling, bruising, scarring, crusting, scabbing or blistering.
* Post treatment instructions including the need to protect the treated area from sun exposure and management of any post treatment skin irritation.

I am aware of the following possible experiences/risks with pulsed light treatment:

* DISCOMFORT and ITCHING – Some discomfort may be experienced during the treatment. Following treatment the area may itch, feel tender, sensitive or warm like a “sunburn” for a few hours or days.
* WOUND HEALING – Treatment can result in immediate or delayed skin reactions including: swelling, blistering, crusting, or scabbing. These skin reactions may last a few hours to 3-4 days or longer. Crusting can .take up to 2 weeks or more to completely flake off.
* BRUISING/SWELLING/INFECTION – Following treatment bruising of the treated area may occur as well as swelling. Bruising and swelling is more likely to be seen with the lasers rather than the IPL. Skin infection is a possibility although rare, whenever a skin procedure is performed, this can include stimulation of dormant infections such as the herpes virus or shingles. It is important to let us know if you have ever had cold sores or shingles.
* PIGMENT CHANGES (Skin Color) or HAIR LOSS – There is a possibility that the skin in the treated area can become either lighter or darker in color compared to the surrounding skin. If this occurs it is usually temporary lasting 1-6 months, but, on a rare occasion, it may be permanent. Hair in the treated area may be removed or reduced, this is generally only temporarily.
* SCARRING – Scarring is a rare occurrence, but it is a possibility when the skin’s surface is treated with a laser or pulsed light device. To minimize the changes of scarring, it is IMPORTANT that you follow all pre and post-treatment instructions carefully and do not pick at or scratch any crusting, or scabs as the skin heals following treatment.
* EYE EXPOSURE – Protective eyewear (shields) must be worn during treatment to protect your eyes from accidental pulsed light or laser exposure.

 **ACKNOWLEDGMENT**

**I UNDERSTAND AND ACKNOWLEDGE THAT PAYMENTS FOR THE ABOVE PROCEDURE ARE NONREFUNDABLE. BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS PERMISSION FORM FOR INTENSE PULSED LIGHT TREATMENT AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME. I HAVE HAD ALL MY QUESTIONS ANSWERED. I FREELY CONSENT TO THE PROPOSED TREATMENT AND UNDERSTAND I CAN AT ANYTIME REVOKE THIS CONSENT AND STOP TREATMENT.**

 **Signature-Patient/Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_**

**Print Name/Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Signature-Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_ Rev 12.11al**