Informed Consent

Name:	Address:
Age:	Phone: e-mail:
Have you previously had laser treatment? If yes, did you have any unwanted side or adverse effects?	
Are you currently taking any medications including aspirin? List all medication alergies !	
How would you estimate your current health status? (select and mark)	Excellent Good Not so good Poor

Filled by Physician:

Laser treatment planned:.....

Person performing the treatment: .....

I was informed that:

- there is no guarantee for success of laser therapy nor for the duration of achieved results
- laser interacts with tissue through photothermal effect, producing thermal tissue remodelling
- there are possibilities for temporary adverse effects as are: redness, edema, scars, burns and pain during the procedure
- at some patients there are possibilities of overreaction due to higher sensiblity which may require immediate medical help (Emergency)
- there are contraindications for laser treatment: pregnancy, diabetes, collagen / scarring / connective tissue disorders and the history of a photosensitivity disorder or use of photosensitizing medication.

I hereby declare that

- I don't have any of contraindications for laser treatment
- I'm accepting the risks to the procedure or treatment proposed as well as possible side effects
- in the case of overreaction to therapy I shall immediately seek a medical help (emergency).

I have read and understand this form and all my questions have been addressed and answered to my satisfaction. I agree to the terms of this agreement.

Date: _____ Signature: _____

Additional text (if desired):

Disclaimer: Informed consent documents are used to communicate information about the proposed treatment of a disease or condition along with disclosure of risks and alternative forms of treatment. The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances. However, informed consent documents should not be considered all inclusive in defining other methods of care and risks encountered. Your physician may provide you with additional or different information which is based on all the facts in your particular case and the state of medical knowledge.

Informed consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

It is important that you read the above information carefully and have all of your questions answered before signing the consent.

1. I hereby authorize _____ and such assistants as may be selected, to perform the following procedure or treatment:

2. I recognize that during the course of the procedure and medical treatment or anesthesia, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above physician and assistants, or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician at the time the procedure is begun.

3. I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve risk and the possibility of complications, injury. and sometimes death.

4. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.

5. I consent to the photographing or televising of the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the picture.

6. For purposes of advancing medical education, I consent to the admittance of observers to the operating room.

7 I consent to the disposal of any tissue, medical devices or body parts which may be removed.

8. I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical-device registration. if applicable.

9. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
   a. THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN
   b. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
   c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-9). I AM SATISFIED WITH THE EXPLANATION.

Patient or Person Authorized to sign for Patient:

Witness: _____ _ Date: _____ _

Patient Initials: _____ _ Date: _____