Lowe Plastic Surgery (LPS)

Laser / IPL Consent

I authorize (healthcare professional's name): ___ Dr. Lowe or his/her Representative_____
to perform Laser/IPL treatments on _____ (patient's name) with the

___Vbeam ___MedLite ___GentleLASE ___Smartxide DOT
___Harmony Pixel ___Harmony ND-YAG ___Harmony IPL ___Other_____

To treat my condition, which is: cosmetic, aging skin, or other skin lesions_____
involving the face, extremities, or trunk_____.

The Laser / IPL is a device that produces an intense but gentle burst of light. This light is absorbed by and causes selective heating of certain cells in your unwanted lesion. Lesions most commonly fade slowly over time as these destroyed cells are eliminated by normal body processes.

My eyes will be covered with laser / IPL -specific safety eyewear or an opaque material to protect them from the intense light. My eyes will be closed and I will not attempt to remove the eye protection during treatment.

I have been informed of the following possible risks and complications of this procedure including but not limited to:

Poor cosmetic result or clinical response
Purpura (red-purple discoloration, bruising)
Itching (hive-like response which lasts 2-3 hours to 2-3 days)
Herpes simplex virus activation
Burns, blisters, scabbing, crusting, skin color and /or textural changes
Hyperpigmentation (darkening of the skin; transient or long term))
Hypopigmentation (lightening of the skin; transient, long term or possibly permanent)
Scarring (possibly permanent)

I understand that complete clearing may not be possible and will depend upon the type, age and color of the lesion. Multiple treatments are needed for the best results. Other methods have been discussed with me such that I may assess the risks and benefits of these alternative treatment methods.

I am aware that external oxygen may not be used during my treatment. Oxygen supports combustion and may cause flash burns in the treatment area. Anesthesia is usually not necessary. My provider or I may elect to use a form of topical anesthesia to reduce discomfort during the procedure. A cryogen spray skin cooling device may be used to decrease discomfort and protect the skin. All anesthesia options and risks have been discussed with me in advance and all my questions have been fully answered and addressed.

I understand that immediately following the laser treatment redness, swelling, discomfort, bruising, and discoloration may develop at the treatment site. I understand that any discoloration may last 7-14 days or longer and swelling should resolve within 10-14 days in most cases. Discomfort may be treated with the application of cool compresses or topical soothing agents.

I have been given complete instructions regarding care and will ask for information if not provided or available. I understand that is important to follow after-care instructions carefully to minimize the chance of incomplete healing, skin textural changes or scarring. It is also important to contact our office if there are any questions or concerns in a timely manner. I understand that if I have a concern that I will report it to Dr. Lowe's office. It is my responsibility to make a timely appointment with Dr. Lowe if my concerns persist, go unanswered, or I simply want to be seen in person.

Patients agree to use sun avoidance and sunblock as recommended for at least 2 months after treatment. Patients understand tanning or certain products should be avoided before and after treatment. That patient agrees to stop all prescribed skin care a week prior and after treatment. I agree not get or seek treatment from others specialist before or after treatment without Dr. Lowe's direct approval. I agree to be honest and report other skin treatment regimens, outcomes, or complications as they may relate to the past, present or future. I agree not to undergo any skin treatments from another within a 2 month recovery period without notifying Dr. Lowe. .

_X_I have provided my past and current medical history and medications.
_X_I consent to clinical observation and care from associated representatives or laser vendors.
_X_I consent to photographs during the course of my laser therapy for healthcare records.
_X_I consent to using my photographs for medical education and /or marketing purposes.
My name will not be used to identify these photographs.
_X_I am not pregnant (female patients).
_X_I have not had an adverse reaction to previous laser treatments or skin regimes

I have been given the opportunity to ask questions about the procedure. My questions have been fully answered and I understand the information given to me.

Contraindications to the performance of this procedure have been discussed in detail with me.

I recognize that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me concerning the results of such procedures.

I have read and understood all information presented to me before signing this consent form now or at any time in the future.

Signed: _____Date:_____

Witness: _____Time:_____