

IPL/Photofacial Consent Form

I _____, consent to and authorize Mark Grimsley, MD or his assistants to perform IPL treatments on me. Phototherapy, despite its high levels of efficacy and safety, is not free of side effects.

Erythema (redness), edema (swelling) and a mild burning sensation much like a sunburn can occur but usually subsides within a few hours

Pigmentary changes such as hyper pigmentation and hypo pigmentation of the skin in the treatment areas can occasionally occur. Most are transient, lasting up to six months, but in rare cases it can be permanent.

Other known complications of this procedure include scarring, keloids, blisters, reddening, bruising, superficial crusting, burns, pain, and infections. Any source of light can active hepetic lesions. If you have a history of viral sores, please inform Dr. Grimsley who may prescribe antiviral medication. You may have an outbreak even if you have no history of viral lesions.

Additionally, there is a known and expected loss of hair in the treated areas. In a very small percentage of people there is new hair growth in the surrounding areas being treated. Even though appropriate measures are taken to reduce side effects, they cannot be completely eliminated in every case. I understand that the treatment may involve risks of complications or injuries from both known and unknown causes, and I freely assume these risks. There may be other treatment options, such as injections, other types of lasers/light sources or peels. With this in mind, I am choosing this non-invasive treatment for vascular and/or pigment lesions and other indicated skin conditions.

Eye damage can occur from the light and therefore protective eyewear must be worn during all phototherapy sessions.

I have read and understand the Pre and Post-Treatment Instructions. I agree to follow these instructions carefully.

I understand that this examination is not meant to replace the necessity for a complete dermatological examination.

No guarantee, warranty, or assurance as been made to me as to the results that may be obtained. I am aware that follow-up treatments may be necessary for desired results. Most patients require a number of treatments over several months with gradual results occurring over this time. Clinical results will vary. I agree to adhere to all safety precautions and regulations during the treatment.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

Client's Name (Please Print):

Client's Signature:

Date
