FACIAL PLASTIC
SURGERY CENTER
A division of Otolaryngology Associates, PC

PIGMENTED LESIONS INFORMED CONSENT FORM

I understand that the removal or lightening of pigmented lesions is a procedure that involves using a laser. Some discomfort may be experienced during laser treatment. I understand that that there is a possibility of rare side effects such as scarring, or permanent discoloration of the area. Other side effects such as swelling, blistering, or a sunburn sensation may occur. Crusting or flaking of the treated area may occur and take up to 3 weeks to slough off. Once any of these conditions have healed, the treated area may still be sensitive to the sun for an additional two to four weeks, or possibly longer in some patients. During the healing process, there is a slight possibility that the treated area can become darker (hyper-pigmentation) or lighter (hypo-pigmentation) in color. If I have a suntan the surrounding area may also lighten. This is usually a temporary condition; however, on a rare occasion it can be permanent. It is **IMPORTANT** that I follow all post-treatment instructions carefully._____ (Patient initial) _____ (Dr/Tech's initial).

I understand that sun exposure, tanning beds, sunless tanning lotions, and tanning creams are to be avoided for at least 4 weeks prior to during, and 4 weeks after the course of laser treatment or I risk a possible pigment change or blistering. Sunscreen of SPF 30 or higher should be applied during the course of treatments. _____ (Patient initial) _____ (Dr/Tech initial).

I understand this procedure involves the use of a laser and the treated area may turn darker in color, flake, or crust. It is a possibility the results will be minimal or not help at all. I realize that each individual's response is different; therefore it could require multiple treatments to achieve desired results. _____ (Patient initial) _____ (Dr/Tech initial).

I understand and agree that Dr. _____ may choose to take photos of my treatment area for the purpose of monitoring my progress. _____ (Patient initial) _____ (Dr/Tech initial).

I also understand that once I've started my treatment program there are no refunds. _____ (Patient initial) _____ MD/Tech initial).

I have received post treatment instructions._____ (Patient initial) _____ (Dr/Tech initial).

Dr. _____ or an employee of Dr. _____ has explained the nature and purpose of pigmented lesion removal, including any risks and possible complications, and it has been discussed the contents of this form with me. I have read and understand this consent form and I agree to its terms and authorize treatment. I further understand that Dr. _____ cannot guarantee the results and I will not hold Dr. _____ or ***his/her*** employees responsible for my individual results of this treatment that I have requested. _____ (Patient initial) _____ (Dr/Tech initial).

Print Patient Name: _____

Patient Signature: _____ Date: _____
(Parent or Guardian if patient is under 18)

Witness: _____Date: _____