FACIAL PLASTIC
SURGERY CENTER
A division of Otolaryngology Associates, PC

LASER VEIN TREATMENT INFORMED CONSENT FORM

I understand that the removal or lightening of dilated superficial veins is a procedure that involves using a laser. Some discomfort may be experienced during laser treatment. I understand that there is a possibility of rare side effects such as scarring or permanent discoloration. Other side effects such as swelling, blistering, crusting, or flaking of the treated area, may require one to three weeks to heal. 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 either lighter (hypo-pigmentation) or darker (hyper-pigmentation) in color compared to the surrounding skin. 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 initial).

I understand that if I've had sun exposure or used a tanning bed within a 3-day period pre or post treatment I risk a possible pigment change or blistering. _____ (Patient initial) _____ (Dr/Tech initial).

I understand that this procedure involves a laser to coagulate the vessels and a bruising effect could last up to 6 months. It is possible the results will be minimal or not help at all. I realize that each individual's treatment 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) _____ (Dr/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 the laser vein treatment, including any risks and possible complications, and has 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 the laser vein 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: _____