

Vbeam Patient Consent Form

Patient Name: _____ DOB: _____

I authorize Southern Tier Dermatology and Aesthetics to perform Candela Vbeam Pulsed Dye Laser therapy to treat _____.

The Vbeam Laser is a device that produces an intense but gentle burst of light that treats the abnormal blood vessels seen in spider veins and other cutaneous vascular lesions without harming the surrounding skin. In addition, the laser treats benign epidermal pigmented lesions including solar lentigines and area of increased brown pigmentation often seen on sun-exposed skin without damaging the surrounding skin. Lesions most commonly fade slowly over time as the treated vessels or areas of pigmentation are eliminated by normal body processes.

My eyes will be covered with laser 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 the procedure including but not limited to:

- * Itching
- * Herpes simplex virus activation
- * Hyperpigmentation
- * Hypopigmentation
- * Burns, Blisters, scabbing, crusting, skin color, and/or textural changes
- * Scarring

I understand that complete clearing may not be possible and will depend upon the type, age and color of the lesion. Multiple treatments may be needed for the best results.

Other methods of treating this condition have been discussed with me such that I may Assess the risks and benefits of these alternative treatment methods.

Anesthesia is usually not necessary. My provider or I may elect to use a form of anesthesia to reduce any discomfort during the procedure. A cryogen spray skin cooling device may be used during the procedure to decrease discomfort and protect the skin. All anesthesia options and risks will be discussed with me in advance.

If oxygen is used during my treatment, my provider will ensure that it is used safely. Oxygen supports combustion and may cause flash burns in the treatment area.

I understand that immediately following the laser treatment redness, swelling, discomfort, bruising, and discoloration may develop at the treatment site. Cold compresses may be applied.

I have been given the opportunity to ask questions about the procedure. All questions have been 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.

_____ I consent to the taking of photographs during the course of my laser therapy for healthcare records.

_____ I consent to using my photographs for medical education and or marketing purposes. My name will not be used to identify these photographs.

_____ I am NOT pregnant (female clients)

I am aware that the treatment that I will be receiving today is a cosmetic procedure and will not be covered by my insurance.

Signature of Patient

Date

Witness