

# CONSENT FOR LASER/LIGHT BASED TREATMENT

I authorize Teresa Folger MD/Amy Garrett ARNP to perform laser/pulsed light cosmetic skin treatments on me, including but not limited to deep tissue heating, soft tissue coagulation, skin resurfacing, hair removal, treatment of pigmented lesions, vascular lesions, acne, wrinkles, scars & stretch marks. I understand that the procedure is purely elective, that the results may vary with each individual & multiple treatments may be necessary.

I understand that:

- Serious complications are rare but possible.
- Common side effects include temporary redness & mild “sunburn” like effects that may last a few hours or up to 3-4 days or longer.
- Pigment changes including lightening or darkening of the skin lasting 1-6 months or longer or permanently may occur. Freckles may temporarily or permanently disappear in treated areas.
- There is a possibility of coincidental hair removal when treating pigmented or vascular lesions or acne in hair-bearing areas.
- Other potential risks include irritation, crusting, blistering, itching, pain, bruising, scaling, flaking, burns, infections, scabbing, transient or longer-lasting swelling, hives, rash, inflammation, ingrown hairs, bleeding, oozing, ulceration, worsening of vessels & failure to achieve the desired result.
- Lasers/intense pulsed light can cause eye injury & protective eyewear must be worn during treatment.
- I understand that sun or tanning lamp exposure, the use of self-tanning creams & not adhering to the after-treatment instructions provided to me may increase my chance of complications.
- There is a potential risk of allergic reaction to any coupling gels or lotions or the numbing anesthetic that may be applied to the skin before treatment. Such risks include temporary swelling, itching & formations of a rash.

I consent to photographs & digital images being taken to evaluate treatment effectiveness, for medical training, &/or professional publications. No photographs or digital images revealing my identity will be used without my express written consent.

Before & after treatment instructions have been discussed with me. The procedure, potential benefits & risks have been explained to my satisfaction. I have had all questions answered to my satisfaction. I freely consent to treatment.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Print name \_\_\_\_\_

Witness signature \_\_\_\_\_ Date \_\_\_\_\_

Print name \_\_\_\_\_

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