INFORMED CONSENT FOR LASER TREATMENT

Dr. Michael Iannotti, MD
Medical Director
303-929-9771

Patient Name _____ Date _____

Service to be Performed _____

Thank you for choosing this independently owned and operated healthcare facility. We hope you have a good experience here with us today.

Possible medical treatment methods include: Laser hair removal, laser vein reduction, laser tattoo removal, laser ablative or non-ablative fractional treatment, laser facial peel, intense pulsed light, collagen remodeling/skin tightening, sun spot/brown spot removal, skin tag removal, cherry hemangiomas removal, Photo Biomodulation treatments with near infrared, radio frequency skin tightening or toenail fungus treatment.

Disclosure: The following problems may occur with the above treatments: you may experience short term itching, stinging, redness, swelling, allergic reaction, dryness, mild burning, temporary bruising or blistering, scabs, crusting, discomfort or a feeing of tingling or numbness around the area treated. Hyper-pigmentation (darkening), hypo-pigmentation (lightening) and texture changes have also been noted after treatment. These conditions usually resolve within 3-6 months, but permanent color change is a rare risk. Avoiding sun exposure before and after the treatment reduces the risk of color change. There is a slight risk of scarring. Though infection following treatment is unusual, bacterial, fungal and viral infections can occur. Herpes simplex viral infections around the mouth can occur following a treatment. This applies to both individuals with a history of herpes simplex virus infections and individuals with no known history of herpes simplex viral infections in the mouth area. If any type of skin infection occurs, additional treatments or medical antibiotics may be necessary. Pinpoint bleeding is rare but can occur following treatment procedures. Should bleeding occur, additional treatment may be necessary. In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations have been reported. Systemic reactions (which are more serious) may result from prescription medicines. There is also the possibility that other side effects or complications, not presently known, recognized, described or understood may develop now or in the future. Other rare risks and complications can occasionally be seen. These include but are not limited to: purpura (purple bruising), infection (picking at the area treated), crusting/scab on ingrown hairs, new growth of treated hair (depending on previous hair removal methods), failure to improve 'quality of life', initial unsightly appearance, interruption of daily life, work routine, home/family life or social life.

Delegation

Dr. Michael Iannotti, MD is licensed to practice medicine in the State of Colorado. He is delegating service to:

Delegatee: _____

Renu Laser and Skin Care
303-470-0200

The service the patient is receiving is a medical service; the delegatee of the service does not have a medical license in the State of Colorado. The delegatee is providing the service pursuant to the delegated authority of the physician; and, the delegating physician is available personally to consult with the patient or provide appropriate evaluation, treatment or referrals in relation to the delegated medical services.

ALL LASER HAIR REMOVAL packages are non-transferable, non-cancellable and non-refundable once treatments have begun.

Acknowledgement

1. I understand the potential benefits of the proposed elective procedure, and alternative treatment options
2. I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.
3. I understand more than one procedure may be needed
4. I have disclosed a full and accurate personal medical history
5. I have read the above disclosure, and by signing below I give consent to proceed with the medical service
6. I have the option to have my consultation performed by Dr. Michael Iannotti, M.D.
7. I understand the procedure and accept the possible complications.
8. I furthermore indemnify the authorized person herein, and Dr. Michael Iannotti, and hold harmless from any and all claims, demands, liabilities, judgments, costs and expenses arising out of any claims relating to the procedure authorized herein.
9. I agree to allow the medical services to be performed by a delegatee of Dr. Michael Iannotti, MD.
10. I understand most insurance companies will not cover this treatment
11. I agree to comply with after-care guidelines which are crucial for skin healing, including protecting my skin with SPF 50+
12. I will not expose my skin to the sun for 72 hours
13. In the event of an adverse reaction I will call the healthcare facility promptly at the number above and the physician is available to meet me

Patient/Guardian Signature _____ Date_____

Delegatee Signature _____ Date_____

Copy - Patient and Patient's Medical Record