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Laser and Skin Care
Laser Vein Removal Informed Consent

Prior to receiving treatment, I have been candid in revealing any condition that may have an effect on this procedure as outlined below. I will also inform Family Medical and Dental Clinic of any changes in my medical history, current medications and/or ant changes relevant to this procedure prior to any future treatments.

I understand that the Cutera (formerly Altus) Laser is intended for vein removal and that clinical results may vary with different skin types, size of vessel being treated, and location. Although rare, I understand there is the possibility of side effects such as scarring and permanent increased or decreased pigmentation, as well as short-term effects such as blistering, reddening, mild burning, bruising and varying degrees of discomfort.

While most patients get satisfactory to excellent results, each patient is different and there is no guarantee as to the success or duration of success that I may achieve. I have been informed that maintenance treatment may be necessary.

Eye protection will be provided to protect the eyes from the laser light. I agree to wear the protective glasses at all times while the laser is in operation.

The contraindications for treatment include: pregnancy, diabetes, history of scarring, use of medications that increase photosensitivity, use of self-tanning lotions, recent and planned sun (and sun lamp) exposure. I certify that I am not currently pregnant and that if I become pregnant during the course of my treatments I will discontinue treatments immediately.

I have reviewed the list of drugs that may cause photosensitivity and understand the potential side effects associated with the laser treatments while using any of the medications on the list. I have provided a complete list of medications I am currently taking including aspirin/aspirin products, ibuprofen (Motrin/Advil), herbal or vitamin supplements.

I am aware of other techniques to treat these conditions, including, but not limited to: sclerotherapy, the closure method, vein stripping, and all other types of lasers.

I realize this procedure is completely elective and will not be covered by my insurance company.

PHOTOGRAPHS: I give permission for photographs to be used by the Family Medical and Dental Clinic staff for education plus promotional purposes. Complete patient confidentiality will be maintained at all times. _____ (Please initial).

I HAVE READ AND FULLY UNDERSTAND THE TERMS WITHIN THE ABOVE CONSENT. ALL MY QUESTIONS HAVE BEEN ADDRESSED TO MY SATISFACTION. IN THE EVENT A DISPUTE ARISES OVER THE OUTCOME OF MY PROCEDURE, I CONSENT SOLEY TO ARBITRATION AS A LEGAL MEANS OF SETTLEMENT. I UNDERSTAND ENGLISH, OR IF I DO NOT, I HAVE APPOINTED SOMEONE TO TRANSLATE CONSENT FORM IN ITS ENTIRETY.

Patient's Name (Please PRINT)	*Translator's name (If applicable) (Please PRINT)*

Patient's Signature	*Translator's Signature (If applicable)*	*Date*
Provider's Name (PRINT)	*Provider's Signature*	*Date*