Bhupendra R. Patel MDSC
9663 Franklin Avenue
Franklin Park, IL 60131
Phone: 847-455-4750
Web: www.PatelMedicalEsthetics.com
or www.PatelFamilyDentist.com

Laser Collagen Remodeling (Laser Toning) 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 Collagen Remodeling (Laser Toning) and that clinical results may vary with different skin types. Although rare, I understand there is the possibility of side effects such as scarring and skin discoloration, as well as common short-term effects such as blistering, reddening, mild burning, bruising, varying degrees of discomfort and temporary discoloration of the skin. These side effects have been fully explained to me _____ (*please initial*).

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, recent 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), and herbal or vitamin supplements.

I am aware of other techniques to treat these conditions, including, but not limited to: FotoFacial, other types of lasers or mid to deep level chemical peels.

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*