

PATIENT CONSENT FORM  
FOR LASER GENESIS SKIN THERAPY

Patient /Client Name: \_\_\_\_\_

Attending Physician: \_\_\_\_\_

I hereby authorize and direct any associates of Dr. \_\_\_\_\_ to perform Laser Genesis Non-Ablative Skin Therapy on me. I understand that this procedure works on promoting vibrant and healthy looking skin. The Laser Genesis procedure is a revolutionary way to combat the signs of aging, without harsh chemicals or long recovery periods.

The following points have been discussed with me:

- Potential benefits of the proposed procedure
- Possible alternative procedures
- Probability of success
- The reasonably anticipated consequences if the procedure is not performed
- The most likely possible complications/risks involved with the proposed procedure and subsequent healing period, including but not limited to, infection, scarring and/or blistering.

I am aware of the following possible experiences/risks with Laser Genesis:

- DISCOMFORT – A slight warming sensation may be experienced during laser treatment.
- WOUND HEALING – Any laser procedure can result in swelling, blistering, crusting or flaking of the treated areas, which may require one to three weeks to heal.
- BRUISING/SWELLING/INFECTION – With some lasers, bruising of the treated area may occur. Additionally, there may be some swelling noted. Finally, skin infection is a rare possibility whenever a skin procedure is performed.
- PIGMENT CHANGES (Skin Color) – There is a slight possibility that the treated skin area can become either hypo-pigmented (lighter), or hyper-pigmented (darker), in color compared to the surrounding skin. This is usually temporary, but on a rare occasion, it may be permanent.
- SCARRING – Scarring is a rare occurrence, but it is a possibility if the skin's surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions carefully.
- EYE EXPOSURE – Protective eyewear (shields) will be provided. It is important to keep these shields on all times during the treatment in order to protect your eyes from accidental pulsed light exposure.
- TREATMENTS – The number of treatments may vary.

ACKNOWLEDGMENT

I UNDERSTAND AND ACKNOWLEDGE THAT PAYMENTS FOR THE ABOVE PROCEDURE ARE NON-REFUNDABLE AND DUE ON THE DAY SERVICES ARE RENDERED. BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THE PERMISSION FORM FOR LASER GENESIS SKIN THERAPY AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.

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Signature of Patient / Guardian

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Print Name / Relationship

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Date