

**Laser Pac *plus*<sup>sm</sup>**  
**Marine Agency Corporation**  
191 Maplewood Avenue, Maplewood NJ 07040  
toll free 800-763-4775, facsimile 973-763-1635

**Required Forms**

Use of the enclosed consent/release forms, medical history forms, post-treatment instructions, and arbitration agreements is required by the policy.

In some cases, Lloyds of London will approve the use of other forms subject to a premium surcharge of up to 20%.

Please sign below and return to confirm that you understand this requirement and will implement use of these forms upon issuance of your insurance policy.

**Signed:** \_\_\_\_\_ **Dated:** \_\_\_\_\_

## CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate laser treatment, we need you to complete the following questionnaire. All information is strictly confidential.

### PERSONAL HISTORY

Client Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Occupation \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Emergency Contact Name and Phone \_\_\_\_\_

How were you referred to us? \_\_\_\_\_

Which of the following best describes your skin type? (Please circle one type number)

- I Always burns, never tans
- II Always burns, sometimes tans
- III Sometimes burns, always tans
- IV Rarely burns, always tans
- V Brown, moderately pigmented skin
- VI Black skin

### MEDICAL HISTORY

Are you currently under the care of a physician?  Yes  No

If yes, for what: \_\_\_\_\_

Are you currently under the care of a dermatologist?  Yes  No

If yes, for what: \_\_\_\_\_

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation?  Yes  No

Do you have any of the following medical conditions? (Please check all that apply)

- Cancer  Diabetes  High blood pressure  Herpes  Arthritis
- Frequent cold sores  HIV/AIDS  Keloid scarring  Skin disease/Skin lesions
- Seizure disorder  Hepatitis  Hormone imbalance  Thyroid imbalance
- Blood clotting abnormalities  Any active infection

Do you have any other health problems or medical conditions? Please list: \_\_\_\_\_

\_\_\_\_\_

Have you ever had an allergic reaction to any of the following? (Please check all that apply and describe the reaction you experienced) Food Latex Aspirin Lidocaine Hydrocortisone Hydroquinone or skin bleaching agents  
Others:

## MEDICATIONS

What oral medications are you presently taking? Birth control pills Hormones

Others (Please list): \_\_\_\_\_

Are you on any mood altering or anti-depression medication? \_\_\_\_\_

Have you ever used Accutane? Yes No If yes, when did you last use it? \_\_\_\_\_

What topical medications or creams are you currently using?  RetinA , Others (Please list):  
\_\_\_\_\_

What herbal supplements do you use regularly? \_\_\_\_\_

## HISTORY

Have you ever had laser hair removal? Yes No

Have you used any of the following hair removal methods in the past six weeks?

Shaving Waxing Electrolysis Plucking Tweezing Stringing Depilatories

Have you had any recent tanning or sun exposure that changed the color of your skin? Yes No

Have you recently used any self-tanning lotions or treatments? Yes No

Do you form thick or raised scars from cuts or burns? Yes No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? Yes No If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_

### **For our female clients:**

Are you pregnant or trying to become pregnant? Yes No Are you breastfeeding? Yes No

Are you using contraception? Yes No

*I certify that the preceding medical, personal and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history. A current medical history is essential for the caregiver to execute appropriate treatment procedures.*

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

## **BOTOX (Botulinum A Toxin) INFORMED CONSENT**

I, \_\_\_\_\_, understand that I will be injected with Botulinum A Toxin (Botox) in the area of the glabella muscles to paralyze these muscles temporarily or in the forehead or crows feet around the lateral area of the eyes.

Botulinum A Toxin (Botox) injection has been FDA approved for use in the cosmetic treatment for glabellar frown lines only – the wrinkles between the eyebrows.

Injection of Botox into the small muscles between the brows causes those specific muscles to halt their function (be paralyzed), thereby improving the appearance of the wrinkles. I understand the goal is to decrease the wrinkles in the treated area. This paralysis is temporary, and re-injection is necessary within three to four months. It has been explained to me that other temporary and more permanent treatments are available.

The possible side effects of Botox include but are not limited to:

- 1. Risks: I understand there is a risk of swelling, rash, headache, local numbness, pain at the injection site, bruising, respiratory problems, and allergic reaction.**
- 2. Infection:** Infections can occur which in most cases are easily treatable but in rare cases a permanent scarring in the area can occur.
3. Most people have lightly swollen pinkish bumps where the injections went in, for a couple of hours or even several days.
4. Although many people with chronic headaches or migraines often get relief from Botox, a small percent of patients get headaches following treatment with Botox, for the first day. In a very small percentage of patients these headaches can persist for several days or weeks.
5. Local numbness, rash, pain at the injection site, flu like symptoms with mild fever, back pain.
6. Respiratory problems such as bronchitis or sinusitis, nausea, dizziness, and tightness or irritation of the skin.
7. Bruising is possible anytime you inject a needle into the skin. This bruising can last for several hours, days, weeks, months and in rare cases the effect of bruising could be permanent.
8. While local weakness of the injected muscles is representative of the expected pharmacological action of Botox, weakness of adjacent muscles may occur as a result of the spread of the toxin.
- 9. Treatments:** I understand more than one injection may be needed to achieve a satisfactory result.

10. Another risk when injecting Botox around the eyes included corneal exposure because people may not be able to blink the eyelids as often as they should to protect the eye. This inability to protect the eye has been associated with damage to the eye as impaired vision, or double vision, which is usually temporary. This reduced blinking has been associated with corneal ulcerations. There are medications that can help lift the eyelid, however, if the drooping is too great the eye drops are not that effective. These side effects can last for several weeks or longer. This occurs in 2-5 percent of patients.
11. I will follow all aftercare instructions as it is crucial I do so for healing.

As Botox is not an exact science, there might be an uneven appearance of the face with some muscles more affected by the Botox than others. In most cases this uneven appearance can be corrected by injecting Botox in the same or nearby muscles. However in some cases this uneven appearance can persist for several weeks or months.

This list is not meant to be inclusive of all possible risks associated with Botox as there are both known and unknown side effects associated with any medication or procedure.

Botox should not be administered to a pregnant or nursing woman.

Additionally,

The number of units injected is an estimate of the amount of Botox required to paralyze the muscles. I understand there is no guarantee of results of any treatment. I understand the regular charge applies to all subsequent treatments.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and reasonable legal fees, should this be required.

By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I hereby give consent to perform this and all subsequent Botox treatments with the above understood. I hereby release the doctor, the person injecting the Botox and the facility from liability associated with this procedure.

*Patient Signature* \_\_\_\_\_ *Date:* \_\_\_\_\_

*Botox Consent (rev 1/12/06)*

## **RESTYLANE & HYLAFORM INFORMED CONSENT**

I, \_\_\_\_\_ understand that I will be injected with Restylane or Hylaform, hyaluronic acid dermal fillers, in the following area(s): \_\_\_\_\_

Restylane/Hylaform are dermal fillers that have been FDA approved for use in cosmetic treatments for moderate to severe wrinkles around the nose and mouth. I understand this treatment is temporary, and re-injection is necessary after about six months. It has been explained to me that other temporary and more permanent treatments are available.

The following complications may occur with the dermal filler injection procedure:

- 1. Risks:** I understand there is a risk of bruising, redness, swelling, pain at the injection site, tenderness, itching, allergic reaction, and raised bumps of skin (nodules). These symptoms are usually mild and typically last a few days but can last up to a few months. In rare cases bruising can last several months and even be permanent.
- 2. Infection:** Post treatment bacterial, viral and/or fungal infections can occur which in most cases are easily treatable but in rare cases a permanent scarring in the area can occur.
- 3. Effectiveness:** Treatments can last anywhere from 4-6 months up to one year.
- 4. Treatments:** I understand more than one injection may be needed to achieve a satisfactory result.
- 5. Allergic Reactions:** In rare cases, there may be an allergic reaction to the injection.
- 6. There is a risk of scarring.**
- 7. I will follow all aftercare instructions as it is crucial I do so for healing.**

As dermal fillers are not an exact science, there might be an uneven appearance of the face with some areas more affected by the fillers than others. In most cases this uneven appearance can be corrected by more injections in the same or nearby areas. However in some cases this uneven appearance can persist for several weeks or months.

This list is not meant to be inclusive of all possible risks associated with dermal fillers as there are both known and unknown side effects associated with any medication or procedure.

Restylane and Hylaform should not be administered to a pregnant or nursing woman.

The number of units injected is an estimate of the amount of Restylane or Hylaform required to add volume to the skin and give the appearance of a smoother face. I understand there is no guarantee of results of any treatment and the regular charge applies to all subsequent treatments.

I understand and agree that all services rendered are charged directly to me and I am personally responsible for payment. I further agree in the event of non-payment, to bear the cost of collection, and/or Court cost and reasonable legal fees, should this be required. By signing below, I acknowledge that I have read the foregoing informed consent and agree to the treatment with its associated risks. I hereby give consent to perform this and all subsequent dermal filler treatments with the above understood. I hereby release the doctor, the person injecting the Restylane or Hylaform and the facility from liability associated with this procedure.

**Patient Signature**

**Date:** \_\_\_\_\_

## Informed Consent for Sclerotherapy

Customer's name: \_\_\_\_\_ Date: \_\_\_\_\_

The purpose of this procedure is to diminish unsightly spider veins. The procedure may require more than one treatment and may produce permanent vein removal. The total number of treatments will vary between individuals. On occasion there are patients that do not respond to treatments.

The following complications may occur with the Sclerotherapy vein removal system:

- 1. Risks: I understand there is a risk of bruising, burning sensation/pain, blood clots, allergic reaction, hyperpigmentation and temporary cramping.** These side effects usually take 1-4 weeks to heal, however pigmentation irregularities can take up to six months to heal.
- 2. Infection:** Although infection following treatment is unusual, bacterial, fungal and viral infections can occur. Should any type of skin infection occur, additional treatments or medical antibiotics may be necessary.
- 3. Effectiveness:** While new veins may appear over time, I understand removal can be permanent.
- 4. Treatments:** I understand removal of veins will take several treatments.
- 5. Allergic Reactions:** In rare cases, there may be an allergic reaction to the sclerosing solution.
- 6. There is a risk of scarring.**
- 7. I will follow all aftercare instructions as it is crucial I do so for healing.**

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

### ACKNOWLEDGMENT:

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release \_\_\_\_\_ (individual) and \_\_\_\_\_ (facility) and \_\_\_\_\_ (doctor) from all liabilities associated with the above indicated procedure.

Client/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Sclerotherapy Technician Signature \_\_\_\_\_ Date \_\_\_\_\_

# Medical Strength Peels

## Client Informed Consent Form

To the CLIENT: You have a right to be informed about your condition and its treatment, so that you may decide whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give, or withhold, your consent for treatment.

1. I voluntarily request that \_\_\_\_\_ perform the Medical Strength Peel procedure. I acknowledge having been informed that this cosmetic procedure is intended to remove surface layers of the skin to improve the vitality of the skin.
2. Medical strength peels, despite their high levels of efficacy and safety, are not free of side effects. Erythema (redness) and edema (swelling) of the treated area can occur but usually subsides within a few hours but can last up to seven days or longer. Irritation, itching, and/or mild burning sensation or pain similar to sunburn may occur within 48 hours of treatment.
3. Pigmentary changes such as hyper pigmentation and hypo pigmentation of the skin in the treated areas can occasionally occur. Mostly it is transient, lasting up to six months, but in rare cases it can be permanent. These pigmentary changes may occur despite appropriate protection from the sun so it is important to use sun screen of SPF 25 or greater when exposed to the sun.
4. I understand complications can include white heads, cold sores, infection, scarring, numbness and permanent discoloration, particularly in people with dark skin.
5. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. I am aware that follow-up treatments may be necessary for desired results. Most patients require a number of treatments over several months with gradual results occurring over this time. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for treatments received.
6. I have read and understand the Pre and Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre and post procedure guidelines are crucial for healing, prevention of scarring, and other side effects and complications such as hyper pigmentation, hypo pigmentation, and other skin textural changes.

I understand and agree that all services rendered to me are charged to me directly and that I am personally responsible for payment.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

I release \_\_\_\_\_, medical staff, and specific technicians from liability associated with the procedure. I certify that I am a competent adult of at least 18 years of age. This consent form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

Note: All prices are subject to change without prior notice

Client's Name (Please Print): \_\_\_\_\_

Client's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Time: \_\_\_\_\_

**SKIN REJUVENATION, ROSACEA & VEINS, and  
non-ABLATIVE WRINKLE WORK  
AFTER CARE FORM**

**Post Treatment Instructions:**

1. Immediately after the treatments, you should apply an ice pack, as there may be mild swelling. It is normal for the treated area to feel like sunburn for a few hours. You should use a cold compress if needed. Avoid any trauma to the skin for up to 2-5 days, such as bathing with very hot water, strenuous exercise, or massage.
2. Avoid picking or scratching the treated skin to achieve your best results. If any crusting, apply antibiotic cream. Some physicians recommend aloe vera gel or some other after sunburn treatment such as Desitin. Darker pigmented people may have more discomfort than lighter skin people and may require the aloe vera gel or an antibiotic ointment longer. Follow instructions as specified by your laser professional.
3. Makeup may be used after the treatment has quit swelling unless there is epidermal bleeding. It is recommended to use new makeup to reduce the possibility of infection. Keep the area moist. Any moisturizer without alpha-hydroxy acids will work.
4. You may shower after the laser treatments in tepid water. The treated area may be washed gently with a mild soap. Skin should be patted dry and NOT rubbed.
5. You will experience redness and bruising from five to fourteen days at the treatment. Avoid direct sun exposure and tanning beds for 1-2 months and throughout the course of the treatment so as to reduce the chance of dark or light spots. Use sunscreen SPF 25 or higher at all times throughout the treatment when going outside.
6. Avoid tweezing, waxing, bleaching or chemical peels during the course of the treatment. Do not use any irritants such as Retin-A, Benzoyl Peroxide or astringents.
7. If work on the leg has been done, wear compression stockings for 48 hours and then during the day while on feet for up to two weeks.
8. Call your physician's office with any questions or concerns you may have after the treatment

## HAIR REMOVAL AFTER CARE FORM

### Post Treatment Instructions:

1. Immediately after the treatments, there should be redness and bumps at the treatment area, which may last up to 2 hours or longer. It is normal for the treated area to feel like sunburn for a few hours. You should use a cold compress if needed. If any crusting, apply antibiotic cream. Some physicians recommend aloe vera gel or some other after sunburn treatment such as Desitin. Darker pigmented people may have more discomfort than lighter skin people and may require the aloe vera gel or an antibiotic ointment longer.
2. Makeup may be used after the treatment, unless there is epidermal blistering. It is recommended to use new makeup to reduce the possibility of infection. Just make sure that you have moisturizer on under your makeup. In fact, moisturizer will help the dead hair exfoliate from the follicle, so use moisturizer frequently and freely on the treated area. Any moisturizer without alpha-hydroxy acids will work.
3. Avoid sun exposure to reduce the chance of dark or light spots for 2 months. Use sunscreen SPF 25 or higher at all times throughout the treatment.
4. Avoid picking or scratching the treated skin. DO NOT USE any other hair removal methods or products on the treated area during the course of your laser treatments, as it will prevent you from achieving your best results.
5. You may shower after the laser treatments, and use soap, deodorant, etc. The treated area may be washed gently with a mild soap. Skin should be patted dry and NOT rubbed. Underarm areas, that have been treated, should be wiped with alcohol for 24 hours. You may apply deodorant after 24 hours.
6. Anywhere from 5-30 days after the treatment, shedding of the hair may occur and this may appear as new hair growth. This is not new hair growth, but dead hair pushing its way out of the follicle. You can help the hair exfoliate by washing or wiping with a washcloth.
7. Hair re-growth occurs at different rates on different areas of the body. New hair growth will not occur for at least three weeks after treatment.
8. Call your physician's office with any questions or concerns you may have after the treatment

Please note: Stubbles, representing dead hair being shed from the hair follicle, will appear within 10-20 days from the treatment date. This is normal and will fall out quickly.

**Informed Consent**  
**For Removal/Reduction of Brown/Age Spots,**  
**Rosacea & Spider Veins**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

I authorize \_\_\_\_\_, to perform the procedure. The light pulsed system may dramatically reduce darkly pigmented sunspots and spider veins. More than one laser session may be necessary to achieve desired results. However, other treatments, including skin care products, are often needed to blend color, reduce sun damage, and give the best results. The FDA has given the clearance for removal of brown spots, spider veins, and rosacea.

The skin treated will be red and swollen with fine, thin scabs forming. Keep the treated areas covered with Polysporin and Aquaphor until the thin scabs fall off. This process will take anywhere from 1-3 weeks. It could take as long as 3-6 months in some rarer cases. Do not scratch the scabs, as that can cause scarring.

*We are unable to treat clients that are on ACCUTANE and PHOTSENSITIZING medications. Clients using ANTICOAGULANTS should be noted.*

The following problems may occur with treatment:

- 1 **Scarring:** The light pulsed system can create a bruising and a moderate burn or blister to the skin. For an effective treatment, the power (joules) needs to be just below the blistering point which means skin will be red. However slight, there is a risk of scarring.
- 2 **Hyper-pigmentation** (browning) and **Hypo-pigmentation** (whitening) have been noted after treatment, especially with a darker complexion. This usually resolves within weeks, but it can take as long as 3-6 months in some cases. Permanent color change is a rare risk. If you have a lot of color in your skin, a skin lightening cream will be advised to reduce the melanin in your skin before the treatment. Avoiding sun exposure after the treatment is crucial to reduce the risk of color change.
- 3 **Infection:** Although infection following pulsed light treatment is unusual, bacterial, fungal, and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a laser treatment. This applies to both individuals with a past history of herpes simplex virus infections in the mouth area. Should any type of skin infection occur, additional treatment including antibiotics might be necessary. **If you have a history of herpes simplex virus in the treated area we recommend preventative therapy.**
- 4 **Bleeding:** Pinpoint bleeding is rare but can occur following brown spot and spider vein treatment procedures. Should bleeding occur, additional treatment might be necessary.
- 5 **Skin tissue pathology:** Energy directed at skin lesions may potentially vaporize the lesion. Laboratory examination of the tissue specimen may not be possible. Only clearly benign pigmented lesions can be treated. Check with your doctor for a clearance for the treatment.
- 6 **Allergic reactions:** 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. Allergic reactions may require additional treatment.
- 7 Wear sunscreen of SPF 25 or higher before and after treatment to protect your skin.
- 8 I understand I may need multiple treatments for the desired outcome.
- 9 I understand that exposure of my eyes to light could harm my vision. I will keep the eye protection on at all times.

10 Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, hyper-pigmentation and hypopigmentation.

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

**ACKNOWLEDGMENT:**

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release \_\_\_\_\_(individual) and \_\_\_\_\_(facility) and \_\_\_\_\_(doctor) from all liabilities associated with the above indicated procedure.

Client/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Laser Technician Signature \_\_\_\_\_ Date \_\_\_\_\_

## Informed Consent for Hair Removal

**Customer's name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Treatment sites: mono-brow, lip, chin, neck, face, arms, fingers, chest, areola, linea, underarms, back, buttocks, bikini, labia, scrotum, thighs, lower legs, feet, and toes.

Combinations: \_\_\_\_\_.

Previous hair removal methods \_\_\_\_\_ (shaving, tweezing, waxing, depilatories, electrolysis, laser)

The purpose of this procedure is to diminish or remove unwanted hair. The procedure requires more than one treatment and may produce permanent hair removal. The total number of treatments will vary between individuals. On occasion there are patients that do not respond to treatments. The treated hair should exfoliate or push out in approximately 2-3 weeks.

Alternative methods are waxing, shaving, electrolysis, and chemical epilation.

The following problems may occur with the hair removal system.

- 1 However slight, **there is a risk of scarring.**
- 2 **Short term effects may include reddening, mild burning, temporary bruising or blistering. Hyper-pigmentation** (browning) and **Hypo-pigmentation** (lightening) 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.  
**Infection:** Although infection following treatment is unusual, bacterial, fungal and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a treatment. This applies to both individuals with a past history of herpes simplex virus infections and individuals with no known history of herpes simplex virus infections in the mouth area. Should any type of skin infection occur, additional treatments or medical antibiotics may be necessary.
- 3 **Bleeding:** Pinpoint bleeding is rare but can occur following treatment procedures. Should bleeding occur, additional treatment may be necessary.
- 4 **Allergic Reactions:** 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.
- 5 I understand that exposure of my eyes to light could harm my vision. I must keep the eye protection goggles on at all times.
- 6 Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, and hyper-pigmentation.

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

### ACKNOWLEDGMENT:

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release \_\_\_\_\_ (individual) and \_\_\_\_\_ (facility) and \_\_\_\_\_ (doctor) from all liabilities associated with the above indicated procedure.

Client/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Laser Technician Signature \_\_\_\_\_ Date \_\_\_\_\_

**CONSENT FORM**  
**for PHOTOFACIAL/SKIN REJUVENATION and/or NON-ABLATIVE WRINKLE REDUCTION**

I \_\_\_\_\_, consent to and authorize \_\_\_\_\_ to perform treatments on me. Light can be used effectively to destroy targets located in the skin with minimum damage to the surrounding tissues. Light is used to lighten, fade or remove photo-damaged skin in a nonablative manner, a procedure known as *photo rejuvenation*. Visible signs of photo damage include wrinkling, enlarged pores, coarse skin texture, and pigment alterations.

Photo-therapy, despite its high levels of efficacy and safety, is not free of side effects. Erythema (redness) and edema (swelling) of the treated area can occur but usually subsides within a few hours but can last up to seven days or longer. Irritation, itching, and/or a mild burning sensation or pain similar to sunburn may occur within 48 hours of treatment.

Pigmentary changes such as hyper pigmentation and hypo pigmentation of the skin in the treated areas can occasionally occur. Mostly it is transient, lasting up to six months, but in rare cases it can be permanent. Most cases of hypo- or hyper-pigmentation occur in people with darker skin or when the treated area has been exposed to sunlight before or after treatment. Occasionally these pigmentary changes occur despite appropriate protection from the sun.

Scarring, which can be hypertrophic or even keloid, is very rare but can occur. Other known complications of this procedure include blisters, reddening, pinpoint pitted scars, bruising, superficial crusting, burns, pain, and infections. These side effects are usually temporary, lasting from five to ten days but can be permanent as well.

The skin at or near the treatment site may become fragile. If this happens, makeup should be avoided and the area should not be rubbed, as this might tear the skin. A blue-purple bruise may appear on the treated area, which might last from five to fifteen days. As the bruise fades, there may be rust-brown discoloration of this skin, which fades in one to three months or longer.

Additionally, there is a known and expected loss of hair in the treated areas. In a very small percent of people there is new hair growth in the surrounding areas being treated.

Even though appropriate measures are taken to reduce side effects, they cannot be completely eliminated in every case. I understand that the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks. There may be other treatment options, such as injections, other types of lasers/light sources or peels. With this in mind, I am choosing this non-invasive treatment for vascular and/or pigment lesions and other indicated skin conditions.

Eye damage can occur from the light and therefore protective eyewear must be worn during all phototherapy sessions.

I have read and understand the Pre and Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre and post procedure guidelines are crucial for healing, prevention of scarring, and other side effects and complications such as hyper pigmentation, hypo pigmentation, and other skin textural changes.

I understand that this examination is not meant to replace the necessity for a complete dermatological examination.

Photographs: I give permission for my photographs to be used to help document my treatment course. Complete confidentiality will be maintained.

No guarantee, warranty, or assurance as been made to me as to the results that may be obtained. I am aware that follow-up treatments may be necessary for desired results. Most patients require a number of treatments over several months with gradual results occurring over this time. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for treatments received.

I understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

The nature and purpose of the treatment have been explained to me. I have read and understand this agreement. All of my questions have been answered to my satisfaction and I consent to the terms of this agreement. Alternative methods of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

I release \_\_\_\_\_, medical staff, and specific technicians from liability associated with this procedure. I certify that I am a competent adult of at least 18 years of age. This Consent Form is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors and assigns.

**Note:** All prices are subject to change without prior notice.

**CLIENT SIGNATURE**\_\_\_\_\_ **Date**\_\_\_\_\_

PATIENT NAME:

## ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must be Arbitrated:** It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

**Article 4: General Provision:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

**Article 6: Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. \_\_\_\_\_. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

PATIENT SIGNATURE X

(Or Patient Representative)

(Indicate relationship if signing for patient)

OFFICE SIGNATURE X

PATIENT NAME:

## CALIFORNIA ARBITRATION AGREEMENT

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must be Arbitrated:** It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

**Article 4: General Provision:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

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PATIENT SIGNATURE **X**

(Or Patient Representative)

(Indicate relationship if signing for patient)

OFFICE SIGNATURE **X**