INFORMED CONSENT FORM

Non-Ablative LaserFACIAL

I understand that erythema is a common immediate reaction from the non-ablative LaserFACIAL treatment process. This typically resolves within 2 hours, but can last longer. There is a possibility of rare side effects such as a blister or swelling that may occur. I may also feel a gentle warming sensation of the skin during treatment. This is a temporary condition and I understand that each person's discomfort level may vary._____ (Patient initial) _____ (Dr/Tech initial).

I understand that 4-6 treatments are required for the non-ablative LaserFACIAL to be most effective. I understand that it is important to follow the recommended maintenance schedule for future treatments to keep the best possible results. I also realize that each individual's treatment response may be different; therefore, the number of treatments may vary to achieve desired results._____ (Patient initial) _____ (Dr/Tech initial).

I understand sun exposure, tanning beds, sunless tanning lotions and tanning creams can cause discoloration or a reaction prior to or during the course of laser treatments. A broad spectrum (UVA/UVB) sunscreen SPF 30 or greater should be applied to the area(s) to be treated whenever exposed to the sun. _____ (Patient initial) _____(Dr/Tech initial).

I understand and agree that Medical Laser Solutions may choose to take photos of my treatment area for the purpose of monitoring my progress._____ (Patient initial) _____ (Dr/Tech initial).

I understand that there is a 24-hour cancellation policy. I understand a **$75.00 minimum fee** or half the treatment cost, whichever is greater, will be charged if I fail to show or do not cancel at least 24 hours prior to my scheduled appointment _____ (Patient initial) _____ (Dr/Tech initial).

I also understand that once I've started my treatment program there are no refunds. _____ (Patient initial) _____ (Dr/Tech initial).

Patients with opened wounds, malignant skin tumors and certain diseases, tattoos, or currently taking Accutane **cannot** be treated._____ (Patient initial) _____ (Dr/Tech initial).

Medical Laser Solutions or an employee of Medical Laser Solutions has explained the nature and purpose of the non-ablative LaserFACIAL, including risks and possible complications, and has discussed the contents of this form with me. I have read and understand this consent form and I agree to its terms and authorize treatment. I further understand that Medical Laser Solutions cannot guarantee the results and I will not hold Medical Laser Solutions or their employees responsible for my individual results of the non-ablative LaserFACIAL that I have requested._____ (Patient initial) _____ (Dr/Tech initial).

Print Patient Name: _____

Patient Signature: _____ Date: _____

(Parent or Guardian if patient is under 18)

Witness: _____ Date: _____