Aesthetic & Laser Center
An Affiliate of Obstetrical and Gynecological Associates OGA

PHOTO-REJUVENATION PATIENT CONSENT

The procedure planned involves use of a Candela Alexandrite Laser device. The purpose of this procedure is to lighten or fade abnormal pigmentation of the skin caused by sun damage or the aging process.

It is important that you notify the technician if you are currently taking any antibiotics, or over the counter (OTC) medications that can cause photosensitivity. It is also important to not be tanning during the entire time period that you are undergoing this procedure.

Some patients, due to their skin type, may be put on a bleaching cream during the treatment phase to help reduce the "down" time as well as to help the treatment be more effective. If that is necessary for you, the skin care specialist will discuss this with you further.

The possible risks or side effects of this procedure include pain, mild swelling, bruising, increase or decrease in skin pigmentation, scarring, or rash. These typically resolve without treatment. The risk of permanent scarring is considered to be extremely small. Multiple treatments are required for optimal results. Some individuals will not respond to the treatment at all and others may need further treatments to correct or treat a complication such as hyperpigmentation. The procedure, the risks and benefits, and the post treatment instructions have been explained to me and I have had my questions answered to my satisfaction. I understand that it is my responsibility to comply with the recommendations for after-care to maximize my results and decrease the risk of unwanted side effects.

I also understand that this procedure is considered cosmetic and is not covered by insurance. I agree to be responsible for all costs of treatment. All questions have been answered, and I voluntarily agree to proceed with this treatment accepting the risks described above. I request that the doctor and/or his/her staff perform this procedure on me.

Patient Signature: _____ Date: _____

Parent Signature: _____ Date: _____
(if under 18 years of age)

Nurse/Esthetician Signature: _____ Date: _____