



## INFORMED CONSENT FOR LASER SKIN TIGHTENING TREATMENTS

Customer's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Treatment Sites: \_\_\_\_\_

The purpose of this procedure is to tighten sagging skin in the area indicated above. The procedure requires more than one treatment and may produce some reduction in the appearance of sagging skin. The total number of treatments will vary between individuals. On occasion there are patients that do not respond to treatments so the outcome cannot be guaranteed. Alternative methods are available from dermatologists or plastic surgeons.

The following problems may occur with the procedure.

1. There is risk of scarring
2. Short term effects may include reddening, mild burning, temporary bruising or blistering. Hyperpigmentation (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.
3. 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.
4. Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, and hyperpigmentation.

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.

Photographs: I hereby consent to grant permission and authorize the use and reproduction by Ink On Ink Off, or anyone authorized by Ink On Ink Off, of any and all "Before and After" photographs taken of me without further compensation to me. The photographs may be included in an advertising brochure, website advertisement or for any other purposes whatsoever. The photographs and all negatives shall constitute the sole property of Ink On Ink Off. I hereby release Ink On Ink Off from any and all liability arising out of the use and reproduction of any photographs.

**Acknowledgment:**

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release the physician and/or any other INK ON INK OFF personnel participating in the rendering of my services from all liabilities associated with the above indicated procedures.

*I acknowledge being advised to and having had an opportunity to consult with an attorney before signing this document. If any term or provision of this document is to any extent invalid, illegal, or incapable of being enforced, such term or provision shall be excluded to the extent of such invalidity, illegality, or unenforceability; all other terms or provisions hereof shall remain in full force and effect.*

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

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