ORTHOMED CLINIC AND SUPPLY

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CONSENT TO PULSED LIGHT-BASED TREATMENT

Date:_____

I, _____*(patient's name)* authorize Orthomed Clinic and Supply and its practitioners/stuff members to perform pulsed light hair removal or pigmented lesion or vascular lesion treatment on me. I understand that the procedure is purely elective.

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.
I understand that: Serious complications are rare, but possible. Common side effects include temporary redness and mild "sunburn" like effects that may last a few hours to 3-4 days or longer. I understand that treatment of benign pigmented lesions and vascular lesions cannot be accomplished without producing some epidermal damage and that this may take 2-4 weeks to resolve.

Pigment changes (light or dark spots on the skin) lasting 1-6 months or longer may occur. In addition, freckles may lighten and/or temporarily or permanently disappear in treated areas. There is the likelihood of coincidental hair removal when treating pigmented/vascular lesions in hair bearing areas.

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.
Other potential risks include blistering, crusting, itching, pain, bruising, skin whitening, burns, infection, scabbing, scarring, swelling, and failure to achieve the desired result. Intense light can cause eye injury and protective eyewear must be worn during treatment.

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.

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.
3. 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.
4. Bleeding: Pinpoint bleeding is rare but can occur following treatment procedures. Should bleeding occur, additional treatment may be necessary.
5. 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.
6. I understand that exposure of my eyes to light could harm my vision. I must keep the eye protection goggles on at all times.
7. Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, and hyper-pigmentation.

I understand that sun exposure or use of tanning lamps or self tanning creams and not adhering to the post-care instructions provided to me may increase my chance of complications.
I understand the importance of having an accurate diagnosis by a physician of brown spots prior to treatment, as treatment of an undiagnosed skin cancer may delay proper medical care.
I understand that since hair follicles generally grow at angles within the skin it is possible to affect follicles that are not directly in the beams apparent path at the skin surface, and for that reason it is not advisable to shape or sculpt precise hair bearing areas such as eyebrows etc.

Before and after treatment instructions have been discussed with me. I have read and understand the attached exclusionary criteria. The procedure as well as potential benefits and risks have been explained to my satisfaction. 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 have had all questions answered. I freely consent to proposed treatment.

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. 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.

I release Orthomed Clinic and Supply, 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. This is to confirm that I do NOT consent to reveal/release my file and all confidential information pertaining to my treatments and any related services to any third party.

Consumer Exclusion Criteria for ANY IPL Treatment

Unprotected sun exposure or use of tanning beds or creams: If you have had unprotected sun exposure in the areas to be treated in the last 4 weeks you must notify your treatment provider. Protected sun exposure means wearing of protecting clothing or use of a SPF #30 or greater sunscreen.
Pregnancy: If you are pregnant you should not have any treatments with light based devices. Although there is no evidence at this time of lethal harm from a light-based system, the results of the treatment may be unreliable due to fluctuations in hormonal level and changes in physiological conditions.
Menstrual dysfunction: If you have menstrual dysfunction or are known to have elevated androgen levels you should see an endocrinologist for evaluation and possible medical treatment. You may tend to have excess hairiness due to your disease, which may respond to medical treatment.
Use of mechanical epilation: Notify your treatment provider if you are seeking hair removal and have used a mechanical epilation method less than 6 weeks prior to treatment. This includes plucking, waxing, tweezing, electrolysis or sugaring.
Allergies: Inform your treatment provider of any allergies to medications, latex, foods or other substances.
History of seizures: If you have a history of seizures or are taking an anti-seizure medication you should not have treatments with a light based devise. Flashing lights may trigger a seizure.
Medications: Inform your treatment provider of both prescription and non-prescription medications you are taking. Be sure to include herbal and natural remedies as some may cause photosensitivity. Consumers should not be taking Accutane, anti-coagulants or St. John's wort.
History of keloid & hypertrophic scar formation: Although scarring is rare, picking or pulling off scabs or crusting can result in scarring. For this reason it is recommended to exclude you from the treatment if you have a known tendency to form keloid or hypertrophic scars.
Active infections/ immunosuppression: Active infections and immunosuppression compromise the healing ability of the body. If you currently have an active infection your treatment will be postponed until the infection is cleared.
Open lesions: Treatment should only be done on intact, health skin.
Herpes I or II within treatment area. If you have a history of herpes outbreaks in the area of the treatment you should consult your physician for medical evaluation and possible prophylaxis prior to treatment.
Tretinoin (Retin-A, Renova): Although tretinoin use in the area to be treated is not absolutely contraindicated, it is however, known to make skin more sensitive and prone to exfoliation. You should be advised to discontinue use of tretinoin and other skin exfoliating products 2 weeks before and during the course of treatment.
Oral Isotretionoin/Accutane: You will be excluded from treatments with the light based device if you have taken Accutane within the preceding 6 months. Accutane changes the underlying structure of the skin, which may cause unreliable results. It may also increase skin sensitivity to light.

This is to confirm that I,_____ have read and understand the attached exclusionary criteria. The procedure as well as potential benefits and risks have been explained to my satisfaction. I have had all questions answered. I freely consent to proposed treatment.

_____ _____
Patient's Name (please print) Patient's Signature