DR SIRUVELLA MD PC
512 GREAT OAKS DR
MONROE, GA 30655

Quanta Light A Star Patient Consent Form

I authorize to perform Light A Star by Quanta on me. The Light A Star by Quanta is a Class IV medical device that uses light energy (755nm or 1064 nm) to selectively heat and destroy the hair follicle or chromophore without harming the surrounding tissue. The Laser is FDA approved device for different cosmetic treatments.

My Eyes will be covered with laser safety eyewear or an opaque material to protect from the different wavelengths delivered from the laser. My eyes will be closed and I will not attempt to remove the protection during any time during the procedure. The sensation can be uncomfortable and may feel like a pen prick or sensation of heat the may last a few hours. Multiple treatments may be necessary to achieve the desired outcome.

I understand the risks of laser procedures area like any other surgical procedure and can include pain, bleeding, infection, scarring, allergic or drug reactions, and Inconvenience to you during the recovery phase. The risk of scarring (in particular raised scars) despite proper laser treatments exists in all cases, but can be reduced by carefully following your aftercare instructions, and by notifying this office if any problems develop.

I will be given complete instructions regarding after care of the treated area. It is important to follow after care instructions to minimize the chance of incomplete healing, skin texture changes or scarring. Sun avoidance and/or use of sun-block may be recommended, tanning should be avoided.

I understand that this is considered cosmetic, and in not covered by health insurance. Our office will NOT bill your insurance for this treatment. Your insurance may or may not cover treatment of any complications should they arise. I understand that I will pay quoted fee for every treatment provided. **I also fully understand that if I fail to keep my appointment without 48 hours of prior notifications, I WILL FORFEIT THE TREATEMENT**

Informed Consent for Treatment

Name: _____

Date: _____

Each treatment you may experience:

- Interruption of daily life, work routine, home/family life or social life
- Initial unsightly appearance
- Itching on or around area treated
- Tingling or feeling of numbness
- Redness and swelling
- Pinpoint bleeding
- Purpura (purple bruising)
- Crusting or scabs

Possible treatment sites:

- Included but not limited to eyebrow, lip, chin, neck, face, arms, fingers, chest, areola, linea, underarms, back, buttocks, bikini, labia, scrotum, thighs, lower legs, feet or toes.
- Possible treatment methods:
- Included but not limited to laser hair removal, laser vein reduction, laser tattoo removal, intense pulsed light, fractional laser resurfacing, sun/age spot removal, skin tag removal or cherry angioma removal.

Short term effects may include:

- Reddening, mild burning, temporary bruising or blistering
- Hyper-pigmentation (darkening) and Hypo-pigmentation (lightening)
- Infection following treatment is unusual but may occur
- Local allergies to tape, preservatives used in cosmetics or topical preparations have been reported

Long term effects may include:

- There is a 1% to 2% risk of scarring
- Herpes simplex virus infections around the mouth can occur to both individuals with a past history of herpes simplex and individuals with no known history of herpes simplex virus infections. If any type of skin infection occurs, additional treatments or medical antibiotics may be necessary
- Systemic reactions may result from prescription medicines you may be currently taking
- There is also the possibility that other side effects or complications, not presently known or recognized, may develop now or in the future. Compliance with the aftercare guidelines is crucial for healing, prevention of scarring and hyper-pigmentation.

Avoiding sun exposure before and after the treatment reduces the risk of skin color change.

ACKNOWLEDGMENT:

- I understand that this is a cosmetic procedure and is completely voluntary
- I have had all of my questions answered by the CLS.
- I am aware that treatments may not meet my expectations.
- I am aware there is a possibility that an imperfection might ensue.
- I understand that exposure to laser light could harm my vision and I must keep the eye protection goggles on at all times.

- I hereby release _____ from all liability associated with the above procedures.

Signature: Date:

_____ _____

Certified Laser Specialist Signature: Date

_____ _____