SIGNATURE
MEDICAL AESTHETICS

CONSENT FOR LASER/LIGHT BASED TREATMENT

I authorize Dr. Siruvella and the dedicated staff at Signature Medical Aesthetics to perform laser/ pulsed light cosmetic treatments on me, including but not limited to deep tissue heating, hair removal, treatment of pigmented lesions, vascular lesions, acne, and/or wrinkles or tattoo removal. I understand that the procedure is purely elective, that the results vary with each individual, and that multiple treatments may be necessary.

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. Pigment changes, including hypopigmentation (lightening of the skin) or hyperpigmentation (darkening of the skin), lasting 1-6 months or longer may occur. In addition, freckles may temporarily or permanently disappear in treated areas. Other potential risks include crusting, itching, pain, bruising, burns, infection, scabbing, scarring, swelling, and failure to achieve the desired result. Lasers/intense light can cause eye injury and protective eyewear must be worn during treatment. I understand that a series of treatments may be required to achieve the desired result.

I understand that sun or tanning lamp exposure and not adhering to the post-care instructions provided to me may increase my chance of complications.

I consent to photographs being taken to evaluate treatment effectiveness, for medical education, training, professional publications or sales purposes. Photographs revealing my identity will not be used without my written consent. If my identity is not revealed, these photographs may be used and displayed publicly without my permission.

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

Patient's Signature:
_____

Date: _____

Print Name:
_____

Witness Signature:
_____

Date: _____

Print Name:
_____

Initial Here and date each treatment.

#2_____ **#3**_____ **#4** _____ **#5**_____
#6_____