Todd H.M. Mirzai, MD and Bao L. Phan, MD
Plastic Surgery

CONSENT TO PULSED LIGHT-BASED TREATMENT

I authorize Dr. Todd H.M. Mirzai and/or Dr. Bao Phan to perform pulsed light hair removal or, pigmented lesion or, vascular lesion treatment on me. I understand that the procedure is purely elective.

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

I understand that treatment of benign pigmented lesions and vascular lesions cannot be accomplished without producing some epidural damage and that this may take 2 weeks to resolve.

I understand that sun exposure or use of tanning lamps or self tanning creams and not adhering to the post-are 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 consent to photographs being taken to evaluate treatment effectiveness, for medical education, training, professional publications or sales purposes. No photographs revealing my identity will 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. 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 my questions answered. I freely consent to the proposed treatment.

_____
Patient's Signature

_____ _____
Printed Name Date

_____
Witness Signature

_____ _____
Printed Name Date