The Vascular & Vein Laser Center
1220 N. Florence Ave.
Claremore, OK 74017
(918)341-5311
Dr. Kyle Hrdlicka & Dr. Lawrence Brotherton

Informed Consent for Photofacial

1. I hereby request and authorize Dr. Hrdlicka or Dr. Brotherton or staff to perform a photofacial procedure. I understand that photofacial involves the use of an intense pulsed light ("IPL") device for the treatment of benign vascular and pigmented lesions. The purpose of the photofacial procedure is to improve the appearance of the skin. Redness, rosacea, sun damage, hyperpigmentation, and irregular pigmentation may be improved with photofacial treatments.

2. I agree to follow the instructions given to me to the best of my ability before, during, and after the above named procedure and that I will, as soon as possible, notify this office of any questionable conditions that may arise.

3. Possible side effects include, but are not limited to: redness, mild burning, temporary bruising or discoloration of the skin. There is a possibility of rare side effects such as scarring and permanent discoloration.

4. I understand that most patients require a series of photofacial treatments in order to achieve the best results. Photofacial treatments are a series of three to five treatments at three to four week intervals with gradual improvement in the skin over time. Clinical results vary from patient to patient.

5. Contraindications to photofacial include pregnancy, use of medications that increase photosensitivity, history of keloid scarring, and recent sun exposure or planned sun exposure. Sun exposure will greatly increase the likelihood of side effects such as hyperpigmentation and must be avoided prior to and following any photofacial procedure.

6. It has been fully explained in terms clear to me the effect and nature of the procedure to be performed, foreseeable risks involved, and alternative methods of treatment. I freely assume these risks.

7. I know the practice of medicine is not an exact science and that, therefore, reputable physicians cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the procedure that I have requested and authorized.

8. I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education, and promotion.

9. I have been given an opportunity to ask questions regarding the matters covered in the preceding paragraphs, and these questions have been answered to my satisfaction.

I understand that this is an elective/cosmetic procedure. Payment is due today. The fee will be: $____________. No guarantees are made or implied regarding the efficacy or duration of this treatment.

Signed: ____ Date: ____________________
(Patient Signature)

Witness: ____ Date: ____________________
(Witness Signature)

Physician: ____ Date: ____________________
(Physician Signature)