INFORMED CONSENT FOR LASER TREATMENT

Darrick Payne, MD
Medical Director
1901 Kipling St., Lakewood, CO 80215

Client Name: _____ Date: _____

Thank you for choosing this independently owned and operated healthcare facility.
We hope you have a good experience with us today.

Possible medical treatment methods include but are not limited to:
Laser hair removal, laser vein reduction, cherry hemangioma removal, sun or brown spot removal, intense pulsed light treatment, skin tag removal, radio frequency skin tightening, micro needle radio frequency treatments, laser circumference reduction, chemical peels and photo biomodulation treatments with near infrared LED's.

The following problems may occur with the above treatments:

- You may experience short term itching, stinging, redness, swelling, allergic reaction, dryness, mild burning, temporary bruising called purpura (purple bruising) or blistering, scabs, crusting, discomfort or a feeling of tingling or numbness around the area treated.
- Hyper-pigmentation (darkening of the skin), hypo-pigmentation (lightening of the skin) and texture changes 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. However slight, there is a slight risk of scarring.
- Though infection following treatment is unusual, bacterial, fungal and viral infections can occur. Herpes simplex viral infections around the mouth can occur following a treatment. This applies to both individuals with a history of herpes simplex virus infections and individuals with no known history of herpes simplex viral infections in the mouth area. If any type of skin infection occurs, additional treatments or prescribed antibiotics may be necessary.
- Pinpoint bleeding is rare but can occur following treatment procedures. Should bleeding occur, additional medical treatments may be necessary.
- In rare cases, local allergies to tape, and preservatives used in topical numbing have been reported. Systemic reactions (which are more serious) may result from prescription medicines. Burns from the laser energy are rare but may require additional medical attention or surgery.
- There is also the possibility that other side effects or complications, not presently known, recognized, described or understood may develop now or in the future. Other rare risks and complications can occasionally be seen including but are not limited to: infection from picking at the area treated, crusting/scab on ingrown hairs, new growth of treated hair (depending on previous hair removal methods), failure to improve 'quality of life', initial unsightly appearance and interruption of daily life, work routine, home/family life or social life.

CONTINUE ON THE OTHER SIDE

Delegation

Darrick Payne M.D. is licensed to practice medicine in the State of Colorado. He is delegating these medical services to Erika's Beauty Lab and acting as its Medical Director. He can be contacted at 720-408-5220.

The service the client is receiving is a medical service; the delegatee of the service does not have a medical license in the State of Colorado. The delegatee is providing the service pursuant to the delegated authority of the physician and, the delegating physician is available to personally consult with the patient or provide appropriate evaluation, treatment or referrals in relation to the delegated medical services.

Acknowledgement

1. I understand the potential benefits of the proposed elective procedure, alternative treatment options and I do not have to have this treatment
2. I understand there are risks in the practice of medicine and that there are NO guarantees of effectiveness.
3. I understand more than one procedure may be needed.
4. I have disclosed a full and accurate personal medical history.
5. I have read the above disclosure, and by signing below I give consent to proceed with the medical service.
6. My questions regarding the procedure have been answered satisfactorily by the laser specialist and I have the option to have my consultation performed by the Medical Director.
7. I understand the procedure and accept the possible complications.
8. I hereby release the laser specialist, clinic, and the Medical Director from all liabilities associated with the above indicated procedure.
9. I understand exposure of my eyes to laser light could harm my vision so I must keep eye protection on at all times.
10. I agree to allow the medical services to be performed by a delegatee of the Medical Director.
11. I understand insurance companies will not cover this treatment.
12. I agree to comply with after-care guidelines which are crucial for skin healing, prevention of scarring and hyper-pigmentation.
13. I will not expose my skin to the sun for 72 hours.
14. In the event of any adverse reaction, I will call the medical director promptly at 720-408-5220 and the physician is available to meet me.

Client Signature: _____ Date: _____

CLIENT INFORMATION & MEDICAL HISTORY

In order to provide you with the most appropriate laser treatment, we need you to complete the following questionnaire. All information is strictly confidential.

PERSONAL HISTORY

Client Name: _____ Today's Date: _____

DOB: _____ Age: _____ Occupation: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email Address: _____ Would you like to be added to our email list to be

the first to find out about specials, discounts, and Erika's Beauty Lab news? □ Yes □ No

Emergency Contact Name and Phone: _____

How did you hear about Erika's Beauty Lab? Please circle one.

Google/Internet Search Social Media (circle one): Instagram Facebook

Friend (Referral Name: _____) Other: _____

Which of the following best describes your skin type? (Circle one type number)

1. Always burns, never tans
2. Always burns, sometimes tans
3. Sometimes burns, always tans
4. Rarely burns, always tans
5. Brown, moderately pigmented skin
6. Black skin

Do you regularly use tanning salons or sun bathe? _____ How often? _____

MEDICAL HISTORY

Are you currently under the care of a physician? □ Yes □ No

If yes, for what? _____

Are you currently under the care of a dermatologist? □ Yes □ No

If yes, for what? _____

Do you have a history of erythema abigne, which is a persistent skin rash produced by prolonged or repeated exposure to moderately intense heat or infrared irritation? □ Yes □ No

Do you have a history of any of the following medical conditions? Check all that apply.

□ Cancer	□ Diabetes	□ High blood pressure	□ Herpes
□ Arthritis	□ Frequent cold sores	□ HIV/AIDS	□ Keloid scarring
□ Skin disease/ Skin lesions	□ Seizure disorder	□ Hepatitis	
□ Hormone imbalance	□ Thyroid imbalance	□ Blood clotting abnormalities	

□ Any active infection(s)?

If yes, please explain: _____

_____

Do you have any other health problems or medical conditions? If yes, please list: _____

_____

_____

_____

_____

Have you ever had an allergic reaction to any of the following? Check all that apply and describe the reaction.

□ Food □ Latex □ Aspirin □ Lidocaine □ Hydrocortisone

□ Hydroquinone or skin bleaching agents □ Other(s): _____

MEDICATIONS

What oral medications are you presently taking?

□ Birth control pills □ Hormones

□ Other(s) (Please list): _____

Are you on any mood altering or anti-depression medication? _____

Have you ever used Accutane? □ Yes □ No If yes, when did you last use it? _____

_____

What topical medications or creams are you currently using? □ Retin-A® □ Other(s) (Please list): _____

_____

What herbal supplements do you use regularly? _____

_____

_____

HISTORY

Have you ever had laser hair removal? □ Yes □ No

Have you used any of the following hair removal methods in the past six weeks?
□ Shaving □ Waxing □ Electrolysis □ Plucking

□ Tweezing □ Stringing □ Depilatories (ex. Nair)

Have you had any recent tanning or sun exposure that changed the color of your skin? □ Yes □ No

Have you recently used any self-tanning lotions or treatments? □ Yes □ No

Do you form thick or raised scars from cuts or burns? □ Yes □ No

Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? □ Yes □ No
If yes, please describe:

_____

_____

FOR FEMALE CLIENTS

Are you pregnant or trying to become pregnant? □ Yes □ No
Are you breastfeeding? □ Yes □ No
Are you using contraception? □Yes □ No

I certify that the preceding medical, personal, and skin history statements are true and correct. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor or nurse of my current medical or health conditions and to update this history accordingly. A current medical history is essential for the caregiver to execute appropriate treatment procedures.

Client Signature: _____ Date: _____