EGÉA

The North Shore's Wellness Spa

AFT Photofacial Disclosure and Consent

Name: _____ Cell Phone:_____

We never sell or share your contact information.

- I voluntarily request AFT laser treatment. I voluntarily consent and authorize that this AFT treatment be performed by the EGEA esthetics staff, under the guidance of Dr. William Fagman. I hereby release EGEA, its staff, and any other participating health care providers from any and all liability for any adverse effects that may result from this treatment and related procedures.
- For record keeping purposes in connection with the treatment I am / will be receiving at EGEA, I consent to before, during, and after treatment close-up photographs of the treated area(s) and the anatomical region surrounding the involved area(s). These photographs will be used for treatment records and be treated with the same confidentiality as the remainder of my records at EGEA.
- I recognize that AFT is not an exact science and I acknowledge that no guarantees or assurances have been made to me as to the result. There are risks related to the performance of these procedures. I understand and acknowledge that the risks that may occur in connection with this particular procedure may include the following:

1) Infection: Albeit rare, skin infection is a possibility any time a skin procedure is performed. I acknowledge and understand that although rare, it is possible for a skin infection to become a blood-borne wide spread infection.
2) Blood clots in veins and lungs: Albeit extremely rare, it may be possible to develop a blood clot associated with this treatment that goes (embolizes) to the heart and/or lungs.
3) Allergic reactions: Although uncommon, I could possibly develop an allergic reaction to medicines applied to the treated area and that I could possibly develop an allergic reaction to any medications that may be prescribed for me.
4) Hemorrhage and bruising: Bruising in the treated area is possible, especially if, within the last ten (10) days, I have taken aspirin or aspirin-containing products, or other medications that "thin" the blood.
5) Recurrence of the lesion: I may not experience permanent results even with multiple treatments.
6) Painful or unattractive scarring: Scarring is a rare complication of laser assisted treatment, but scarring is possible because the skin surface is disrupted by the laser. To minimize the chances of scarring, it is most important that I follow *all postoperative instructions* carefully.
7) Discomfort and pain: Some discomfort will be experienced during and after the laser treatment. I give my permission for the administration of topical anesthesia when and if deemed appropriate.
8) Pigment changes (skin color): During the healing process, the treated area may become either lighter or darker in color than the surrounding skin. This is usually temporary, but on a rare occasion, it may be permanent.
9) Poor healing: The resultant open wound may require more than the usual one to three weeks to heal.
10) Sun exposure: Treated areas may be sensitive to the sun. Treated areas should be blocked completely with a sun block with SPF greater than 40 at all times in areas not protected by clothing, whether or not I am in the sun.
11) Blindness and eye damage: The laser, without protective eyewear, may cause visual loss including blindness. *It is important to keep these shields on at all times during* the procedure and I *should keep my eyes closed* in order to protect my eyes from accidental laser exposure.

- I understand and acknowledge that multiple treatments are required to achieve long-term results and that some patients have no results even with multiple treatments. I understand that the usual number of treatments required is six, but more treatments may be necessary. _____(client's initials)
- I agree to stay out of the sun and/or to use sufficient sun block for **FOUR** weeks after each treatment. I understand that failure to use sun block may diminish results. ____(client's initials)
- I have been given an opportunity to ask questions about alternate forms of anesthesia and treatment, the procedure, and the risks and hazards involved, and I believe that I have sufficient information to give the informed consent. By signing below, I certify that I have read and fully understand the contents of this document and that I have received and understand all of the disclosures referred to herein. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian having legal custody will also be required before treatment.

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Signature of Client Date