



## IPL(Intense Pulsed Light) Consent

Patient Name: \_\_\_\_\_

### Purpose

A multi-application light therapy for the reduction of pigmentation, liver/age spots, sun damage, rosacea, facial veins, hemangiomas (red spots), and enlarged pores.

### Procedure

The Palomar System delivers a precise pulse light energy that is absorbed by pigment or by the blood in the skin. The heat dissolves the cells that create unwanted pigment and/or shrinks the unattractive blood vessels. Treatments are scheduled 4 weeks apart. To achieve the best results a series of 3-4 treatments is suggested. Maintenance treatment may be required to maintain benefits at 3-6 month intervals.

### Risks/Discomforts

This procedure requires no sedation or anesthetic. During procedure you may feel a mild stringing sensation followed by heat. This sensation dissipates gradually after treatment. Slight redness and swelling may be present following the treatment. Risk of the procedure are rare but include blistering, bruising, flare up of existing herpes or bacterial infections, swelling, scabbing, hair loss, or change in pigmentation. Color changes are more common in darker skin (including tanned skin) and may take up to 12 months to return to normal. Some changes may be permanent. Dissatisfaction with the result is also a potential with any cosmetic procedure.

### Before Treatment

- Do not tan for at least 3 weeks prior or post treatment
- Stop all Aspirin, Aspirin containing medications, anti-coagulants, topical Retin-A (or similar medications), and Alpha Hydroxy Acids.
- No alcohol on the day of the treatment.
- Stop any sun sensitizing medications.

### Questions

The Licensed Medical Esthetician has explained the nature of the procedure and its alternative treatments. The benefits and risks have been explained and any questions answered. Any further questions may be answered by calling 907-357-9590. This document is written confirmation of this discussion.

### Consent

I have read this form and understand the potential risk and expected outcome. I understand that there are no guarantees as to the outcome of the treatments and I accept the possibility of the above complications. I have had the opportunity to discuss my concerns with the provider and ask questions. I consent to the Photojuvenation treatment.

Patient  
Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_