

West Georgia Laser Center
Consent for Laser Genesis Procedure

Name: _____ Attending Physician _____

I hereby authorize and direct any associates of West Georgia Laser Aesthetics Center to perform Laser Genesis Non Ablative skin therapy on me. I understand this procedure works on promoting vibrant and healthy looking skin. The Laser Genesis procedure is a revolutionary way to combat the signs of aging, without harsh chemicals or long recovery periods.

The following points have been discussed with me:

- The potential benefits of the proposed procedure.
- The possible alternative procedures
- The probability of success.
- The reasonably anticipated consequences if the procedure is not performed.
- The most likely possible complications/risks involved with the proposed procedure and subsequent healing period, including, but not limited to, infection, scarring, crusting, re-growth of hair, and/or blistering.
- Post treatment instructions.

I am aware of the following possible experiences/risk with Laser Surgery:

- DISCOMFORT: Some discomfort may be experienced during laser treatment
- WOUND HEALING: Laser Surgery can result in swelling, blistering, crusting, or flaking of the treated areas, which may require one to three weeks to heal. Once the surface has healed, it may be pink or sensitive to the sun for an additional two to four weeks, or longer in some patients.
- BRUISING/SWELLING/INFECTION: With some lasers, bruising of the treated area may occur. Additionally, there may be some swelling noted. Finally, skin infection is a possibility although rare, whenever a skin procedure is performed.
- PIGMENT CHANGES (Skin Color): During the healing process, there is a slight possibility that the treated area can become either lighter or darker in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- SCARRING: Scarring is a rare occurrence, but it is a possibility when the skin's surface is disrupted. To minimize the changes of scarring, it is IMPORTANT that you follow all post-treatment instructions carefully.
- EYE EXPOSURE: Protective eyewear (shields) will be provided. It is important to keep these shields on at all times during the treatment in order to protect your eyes from accidental laser exposure.

ACKNOWLEDGEMENT

I UNDERSTAND AND ACKNOWLEDGE THAT PAYMENTS FOR THE ABOVE PROCEDURE ARE NON REFUNDABLE.

BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS PERMISSION FORM FOR LASER HAIR REMOVAL TREATMENT AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.

Signature-Patient or Guardian

Print Name/Relationship

Date

Signature-Witness/Representative

Print Name/Relationship

Date