Evergreen LASER
Laser Hair Removal & Med Spa

ABLATION AND SKIN RESURFACING BY OPUS PLASMA CONSENT FORM

Patient Name: _____ Date: _____

Reason for visit (area to be treated):

_____

What medications are you taking (including aspirin)? Please list:

_____

_____

Are you taking any herbal preparations (ex. St. John'sWort, etc.)? Please list:

_____

_____

Contraindications:

YES NO

- ☐ ☐ Current or history of cancer, especially malignant melanoma or recurrent non-melanoma skin cancer, or pre-cancerous lesions such as multiple dysplastic nevi
- ☐ ☐ Any active infection
- ☐ ☐ Diseases that may be stimulated by light at 515 nm to 1200 nm, such as a history of recurrent herpes Simplex, Systemic
- ☐ ☐ Lupus Erythematosus, or Porphyria
- ☐ ☐ Use of photosensitive medication and/or herbs that may cause sensitivity to 515 - 1200 nm light exposure, such as Isotretinoin, tetracycline, or St. John's Wort

YES NO

- ☐ ☐ Immunosuppressive diseases, including AIDS and HIV infection, or use of immunosuppressive medications
- ☐ ☐ Patient history of Hormonal or endocrine disorders, such as polycystic ovary syndrome or diabetes, unless under control.
- ☐ ☐ History of bleeding coagulopathies, or use of anticoagulants
- ☐ ☐ History of keloid scarring
- ☐ ☐ Dehydrated skin (dry skin)
- ☐ ☐ Exposure to the sun or artificial tanning during the 3–4 weeks before treatment light-sensitive medication
- ☐ ☐ Are you pregnant?
- ☐ ☐ Do you wear contact lenses?

Daily consumption of alcohol:

_____

_____

_____

Allergies (Please list):

_____

_____

_____

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Skin type (when exposed to the sun without protection for about 1 hour)

_____

Do you use chemical sun tanning lotions?

_____

When were you last exposed to the sun (including the tanning booth)?

_____

Are you planning a vacation in the sun?

_____

Please Initial:

_____ **The Procedure**: I have requested that the Aestheticians, under the supervision of a physician at the Evergreen Laser & Med Spa performs the following procedure “ablation and resurfacing of the skin. Opus Plasma by Alma Laser”.

_____ **Risks**: There are risks related to the performance of this Procedure. I understand and acknowledge that the risks that may occur in connection with this Procedure may include the following:
a. Discomfort, pain, rarely very superficial burn and redness of the skin – I acknowledge that I will experience some discomfort during and after the Procedure.
b. 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.

_____ Contraindications: I acknowledge that I have been informed of certain conditions that must be met to perform the procedure.
a. Pregnancy I am not pregnant

_____ No Guarantee of Success I recognize that this Procedure is not an exact science, and I acknowledge that no guarantees or assurances have been made to me as to the results that will be achieved. Multiple Procedures may be required and that success may not be achieved even then.

_____ I Consent to Photography For the purposes of accurate record-keeping in connection with the care and treatment which I am receiving and will subsequently receive from the Clinic, I at this moment consent to have the Clinic’s staff take before, during, and after close-up treatment photographs of the involved area (s)
and the anatomical region surrounding the involved area (s). These photographs shall be used for medical records only and treated with the same confidentiality as the remainder of my record at the Clinic.

_____ I have been allowed to ask questions about my condition and treatment, the procedure to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent. By signing below, I certify that I have read and fully understand the contents of this document.

The nature and purpose of the treatment have been explained to me. I have read and understood this agreement that I completed on "today's date," stated on pages one of two on this consent form. All of my questions have been answered to my satisfaction, and I consent to the terms of this agreement. Alternative treatment methods and their risks and benefits have been explained to me, and I understand that I have the right to refuse treatment. 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 update my records. Recent medical history is essential for the caregiver to execute appropriate treatment procedures.

_____
PRINTED NAME OF PATIENT (FIRST, LAST)

_____
PATIENT SIGNATURE
(OR SIGNATURE OF LEGAL GUARDIAN IF PATIENT IS UNDER 18)