Evergreen LASER
Laser Hair Removal & Med Spa

Medical Strength Peels
Informed Consent

Patient Name: _____ Date: _____

To the CLIENT: You have a right to be informed about your condition and its treatment so that you may decide whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give, or withhold, your consent for treatment.

This form is designed to provide detailed information regarding Removal/Reduction of Brown/Age Spots, Rosacea, Acne & Spider Veins (hereinafter the "Treatment"). Please read this form thoroughly and make sure all your questions are answered before deciding to undergo treatment. After reading this document, **please initial** each section, and date the appropriate areas.

_____ Prior to receiving treatment I have communicated with the Practitioner about any conditions or medications that may contraindicate this procedure.

_____ I voluntarily request that Evergreen Laser perform the Medical Strength Peel procedure. I acknowledge having been informed that this cosmetic procedure is intended to remove surface layers of the skin to improve the vitality of the skin

_____ Medical strength peels, despite their high levels of efficacy and safety, are not free of side effects. Erythema (redness) and edema (swelling) of the treated area can occur but usually subsides within a few hours but can last up to seven days or longer. Irritation, itching, and/or mild burning sensation or pain similar to sunburn may occur within 48 hours of treatment.

_____ Pigmentary changes such as hyperpigmentation and hypopigmentation of the skin in the treated areas can occasionally occur. Mostly it is transient, lasting up to six months, but in rare cases, it can be permanent. These pigmentary changes may occur despite appropriate protection from the sun so it is important to use sunscreen of SPF 25 or greater when exposed to the sun.

_____ I understand complications can include whiteheads, cold sores, infection, scarring, numbness, and permanent discoloration, particularly in people with dark skin.

_____ No guarantee, warranty, or assurance has been made to me as to the results that may be obtained. I am aware that follow-up treatments may be necessary for desired results. Most patients require a number of treatments over several months with gradual results occurring over this time. Clinical results will vary per patient. I agree to adhere to all safety precautions and regulations during the treatment. No refunds will be given for treatments received.

_____ I have read and understand the Pre and Post-Treatment Instructions. I agree to follow these instructions carefully. I understand that compliance with recommended pre and post-procedure guidelines is crucial for healing, prevention of scarring, and other side effects and complications such as hyperpigmentation, hypopigmentation, and other skin textural changes.

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_____ I understand that generally, a series of 3-4 treatments are recommended for optimal results. However, the number of treatments required will depend on each patient's level of skin correction needed. Treatments are generally performed once every two to four weeks, and maintenance treatments are usually recommended every three months to help prevent the aging of the skin.

_____ I understand that for optimal results, I will be given and must follow all post-treatment instructions. These instructions will be given to me verbally and written; all provided alongside my post-treatment kit.

_____ I understand peeling typically lasts seven days, and results are generally seen within a week once peeling has subsided. However, continued improvement to the skin may be seen even months after treatment.

_____ 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 understand and agree that all services rendered to me are charged directly and that I am personally responsible for payment.

I understand the results may vary, and there are **NO REFUNDS**.

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.

I release Evergreen Laser, its medical staff, and technicians from liability associated with the procedure.
I certify that I am a competent adult at least 18 years of age.

This consent form is freely and voluntarily executed and binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns.

Note: All prices are subject to change without prior notice

PRINTED NAME OF PATIENT (FIRST, LAST)

PATIENT SIGNATURE