CONSENT FOR VASCULAR TREATMENT AT NORCAL DERMATOLOGY & COSMETIC

I authorize **Dr. Truong/Dr. DeGroot or certified provider** to perform light-based treatments on me to treat vascular lesions such as broken capillaries, telangiectasia, excessive redness. I understand that procedure is purely elective, that the results may vary with each individual, and multiple treatments maybe necessary. I have read and understand the pre- and post- care instructions given to me prior to treatment.

I understand that:

- The sensation of light may feel like a moderate to severe pinprick or flash of heat. If the practitioner elects to use an anesthetic to reduce the discomfort, all options and risks associated with the anesthetic will be discussed with me. The treated area may be red and swollen for 2–24 hours or longer. Cooling the area after the treatment (e.g. ice packs, and topical gels) may help reduce the discomfort.
- Common side effects include temporary redness or mild "sunburn"-like effect that may last a few hours to 3-4 days or longer. Other potential side effects include, but are not limited to, crusting, irritation, itching, pain, burns, scabbing, swelling, broken capillaries, bronzing, acne or herpetic breakouts. There also is a risk of resulting unsatisfactory appearance and failure to achieve the desired result.
- Pigment changes, including hypopigmentation (lightening of the skin) or hyperpigmentation (darkening of the skin), lasting one to six (1-6) months or longer may occur.
- Serious complications are rare but possible, such as, scarring and allergic reaction to medications or materials used during the procedure. There is no guarantee that the expected results will be achieved.
- Sun, tanning bed, or tanning lamp exposure, use of self-tanning creams, and not adhering to the written pre- and post-treatment instructions provided may increase my chance of complications. Therefore, I must avoid the sun, tanning beds, and sunless tanning lotions and use sunblock (at least SPF 45) after treatment.
- I should call my provider as soon as possible if I have any concerns about side effects or complications after treatment. I hereby consent to the administration of any anesthesia or sedation considered necessary or advisable for my procedure(s). I understand that all forms of anesthesia and sedation involve risk and the possibility of complications. Not providing my medical history before proceeding with a light-based treatment could impact treatment results and cause complications.

I consent to photographs and digital images being taken and used to evaluate treatment effectiveness, for medical education, training, professional publications or sales purposes as long as my identity is not revealed. No photographs or digital images revealing my identity will be used without my written consent.

Before and after-treatment instructions have been given and discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction. I also understand that because results may vary among individuals, there will be no refund should the results do not meet my expectation.

I have read and understand all information presented to me before consenting to treatment. I have had all my questions answered. I freely consent to the treatment today and any future treatments as necessary.

Patient Signature: _____ Print name: _____Date _____

Witness signature: _____ Print name: _____ Date: _____

Revised 2/21/13