CO2 FRACTIONAL LASER SKIN RESURFACING

Informed Consent for Treatment

Patient Name____ Date_________________________

Procedure____

I_______________________ hereby request and authorize Laser Magic to perform Sandstone Matrix Fractional Laser Skin Resurfacing on my ____ ________

I understand the Sandstone Matrix Fractional Skin Resurfacing laser is an FDA cleared device. I have had time to discuss my indications and the treatment with my physician and all of my questions have been answered to my satisfaction. I have adequate knowledge of the procedure to sign an informed consent for treatment.

I understand that treatment is contraindicated in patients currently taking anti-coagulants, active skin infection, isotretinoin use in the past year (i.e. Accutane), compromised immune system, impaired healing(e.g. keloid scar formers), pregnancy and skin cancer in the treatment area.

I understand that the Sandstone Matrix fractional laser is a Class IV Carbon Dioxide laser and that I must keep my eyes closed during the treatment and my eyes will be covered during treatment.

I understand that clinical results may vary depending on my response to treatment and my compliance with pre and post treatment instructions.

I also understand that possible complications and risks include scarring, pigment changes, infection, swelling and prolonged redness of the treated skin.

I consent to taking photographs and authorize their anonymous use for public education, medical study or research and documentation for my medical records.__________________________(Pt. initials).

I do not consent to photographs being shared outside of Laser Magic_________ (Pt. initials).

I understand and will follow the doctor’s recommendations for post treatment care of my skin.

I understand that no guarantee has been given to me with regard to the percentage of improvement of my skin and that more than one fractional laser skin resurfacing treatment may be necessary to achieve the desired results.

Patient (Print Name) ____

(Signature)_____________________________ Date___________________

Laser Magic Rep (Print Name) ____

(Signature)_____________________________ Date___________________