Dermatology Associates Medical Group Laser Center
465 N. Roxbury Drive, Suite 801
Beverly Hills, CA 90210
(310) 274-9954 ext. 227

VBEAM CONSENT FORM

The Candela Vbeam produces an intense but gentle burst of light that treats abnormal blood vessels and redness of the skin without harming the surrounding tissue. Depending on the size and color of the lesions being treated, complete clearing may not be possible and may take multiple treatments for the best results.

I understand that immediately following the laser treatment the area may appear as a red or bruised discoloration and may be swollen. I understand any discoloration or swelling may last several hours to several days. Improper care of the treated area while the discoloration is present may increase the chance of scarring or skin textural changes to the treated area.

I have been informed that scarring, hypopigmentation (lightening of pigment) and hyperpigmentation (darkening of pigment) are possible risks and complications of this procedure. I understand that no guarantee can be given as to the final results obtained. I am aware that while some individuals may experience significant improvement, it is possible that these treatments may not work for me.

I consent to the taking of photographs during the course of my laser therapy for the purpose of monitoring the progress of treatment. These photographs will remain in the medical chart and will not be used for any other purposes.

I have read and understood all information presented to me before signing this consent.

Mobile number:** _____ (or best number to reach you on the ***day of appointment)

***Patient Signature:** _____ **Date:** _____

***Patient Name:** _____
(Please Print)

Witness: _____ Date: _____

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Patient Medical History

1. **Location of concern (e.g. areas of face, neck) to be treated:**
   _____

2. **Have you ever been treated for this/these problem(s)? Yes_____ No_____**
   When?_____
   What method of treatment? _____

3. **Do you have any medication allergies? (Please list) _____**
   Any skin related allergies? (Please list) _____

4. **Do you have a history of HSV (cold sores, fever blisters)? Yes _____No _____**

5. **Some medication may increase sun/light sensitivity and/or cause bruising. These include:** ***Aspirin, Ibuprofen, Anticancer drugs, Antihistamines, Antibiotics, Antidepressants, Diuretics, Antihypertensives, Anti-inflammatory, and Antiparasitics. It is important that you inform the Doctor/RN of any future changes or additions to your medications.***

   Please list <u>all current medications</u>, including oral, topical, over-the-counter, and herbal supplements:

   _____ _____
   _____ _____
   _____ _____
   _____ _____

   Please indicate if you are currently using any of these medications/products:

   Retin-A? Yes_____ No _____ if Yes, date of last use: _____

   Glycolic Acid? Yes _____ No _____ if Yes, date of last use: _____

   Topical Cortisone? Yes _____ No _____ if Yes, date of last use: _____

6. **(For Female Patients) Are you pregnant? Yes _____ No _____**

7. **Have you taken Accutane within the last six months? Yes _____ No_____**
   If so, when was your last dose? _____

8. **Have you had any alcohol in the last 48 hours? Yes _____ No _____**

9. **Have you had recent sun exposure in the area to be treated?**
   Yes_____ No _____ If yes, when? _____

10. **Do you use self-tanners ("fake tan")? Yes _____ No _____**
    If yes, then when was the last application? _____

11. **Do you use a sunscreen? Yes _____ No _____**
    If so, how often do you apply? _____ What is the SPF? _____

12. **Have you ever been diagnosed with a disorder associated with photosensitivity (For example, systemic lupus erythematosus)?**
    Yes_____ No _____

13. **Do you have any cosmetic tattoos/permanent makeup on your face?**
    Yes _____No _____ if so, where? _____

Patient Signature: _____ Date: _____

Patient Name: _____
(Please Print)

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TOPICAL ANESTHETIC CONSENT

Some patients experience mild to moderate discomfort during the laser treatments. For this reason we offer the use of a topical anesthetic cream. In some instances, the cream may cause a temporary local irritation in individuals who are sensitive to the active ingredients. Although very rare, other more serious side effects can occur. People with a known sensitivity to local anesthetics (Benzocaine, Lidocaine, Tetracaine) should not use this product. If you have been diagnosed with a cardiac or liver condition, take cardiac medication, or are currently pregnant or breastfeeding you should not use this product. This product will not be applied to large surface areas or multiple body sections during a single procedure.

I am choosing to use a topical anesthetic for my laser/light treatment. I have no known allergies/sensitivity to Benzocaine, Lidocaine, or Tetracaine. I understand the potential risks and I have informed the Registered Nurse of my current medical conditions and/or medications.

_____ _____

Patient Date

_____ _____

Witness Date

DERMATOLOGY ASSOCIATES MEDICAL GROUP
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PATIENT CANCELLATION POLICY

DERMATOLOGY ASSOCIATES MEDICAL GROUP LASER CENTER HAS A 24-HOUR CANCELLATION POLICY FOR COSMETIC PROCEDURES. THESE PROCEDURES INCLUDE ALL LASER, INTENSE PULSE LIGHT AND AESTHETIC TREATMENTS.

I UNDERSTAND THAT I WILL BE CHARGED $100.00 IN THE EVENT THAT MY COSMETIC PROCEDURE APPOINTMENT IS NOT CANCELLED 24 HOURS IN ADVANCE.

IN ORDER TO PROVIDE THE BEST POSSIBLE SERVICE TO ALL OF OUR PATIENTS, WE ASK THAT YOU ARRIVE AT YOUR SCHEDULED APPOINTMENT TIME. **LATE ARRIVALS MAY HAVE TO BE RESCHEDULED AND THE CANCELLATION FEE WILL APPLY.**

Patient: _____ Date: _____

Witness: _____ Date: _____