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

INTENSE PULSED LIGHT (IPL) CONSENT FORM

The Lumenis One is an intense pulsed light (IPL) device used for the treatment of benign pigmented and vascular skin lesions. IPL treatments are a series of approximately 3 treatments performed at approximately 4-week intervals. Actual results vary from patient to patient. The IPL treatment is a cosmetic procedure and insurance is not accepted.

The procedure is contraindicated in the following situations: pregnancy, the use of medications that cause photosensitivity (sensitivity to sunlight/light), the use of anticoagulants (blood thinners), a history of bleeding disorders, sun exposure (tanning) 3 weeks prior to treatment, or planned sun exposure within 1 week after any treatment. Diseases that increase sensitivity to sunlight/light (Lupus/SLE) or very dark skin types also should not undergo IPL treatments.

I understand that there are possible risks to these treatments, similar to any other medical procedure. These risks include rare side effects such as scarring and permanent skin discoloration as well as short-term effects such as redness, burning, bruising and temporary skin discoloration. These side effects have all been fully explained to me and I accept the risks of the IPL treatment series.

I understand that IPL treatments may affect hair growth. For this reason we do not treat over men's bearded areas unless expressly discussed with the R.N.

To achieve optimal results from the IPL treatment series, we strongly encourage maintenance treatments. Usually this consists of 1 treatment every 4-6 months.

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 certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

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

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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: _______________