



Fractionated Co2 Patient Consent

Patient Name _____

Treatment sites _____ I duly

authorize _____ to use the Fractional

CO2 laser system to perform ablative skin resurfacing and any post treatment medical requirements that may be necessary. _____ I understand that the Fractional CO2 laser

is a laser device designed for ablative skin resurfacing and that clinical results may vary in different skin types. I understand there is a possibility of short-term effects such as

reddening, blistering, scabbing, temporary bruising, and temporary discoloration of the skin. _____ I understand there is a possibility of other short-term effects such as post

procedure burning sensations or pain, swelling of the treatment area, a visible dot pattern of the skin in the treatment area, sensitivity to touch and a "social down time" of

3-7 days. _____ I understand that rare side effects such as scarring and permanent discoloration can occur. These effects have been fully explained to me. I have discussed

any history I have regarding poor healing or abnormal scar formation. _____ I

understand that if I am prone to fever blisters that could occur and I need to alert the medical staff so they could give me a prescription for anti-viral medication to prevent this

occurring. _____ Clinical results may vary depending on individual factors, including medical history, amount of sun damage or textural problems, skin type, patient

compliance with pre/post treatment instructions, and individual response to treatment.

_____ I understand that treatment by the Fractional CO2 laser system may involve a

series of treatments and the fee structure has been fully explained to me. _____ I certify

that I have been fully informed of the nature and purpose of the procedure, expected

outcomes and possible complications. _____ I understand that medicine is not an exact

science, and that there are no guarantees in regard to treatment results. I am fully aware

that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. _____ I confirm that I am not pregnant at this time, and that I have not taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator. I also have completed a medical history checklist and been informed about what I may or not do before, during, and after the procedure. _____ I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit education and promotion. _____ I certify that I have been given post treatment care instructions and the opportunity to ask questions and that I have read and fully understand the contents of this consent form. With all of the above information understood, I am choosing to be treated with the Fractional CO2 laser.

Patient Signature: _____ Date: _____

Witness _____