NADOMI
MEDSPA

INFORMED CONSENT FOR LASER GENESIS®

Patient Name: _____ Nurse: _____

Treatment site(s): _____

The purpose of this procedure is to target fine lines, rosacea, acne, acne scars, large pores, and uneven skin tone by heating the dermis of your skin, to accelerate collagen regrowth. The total number of recommended treatments will vary between individuals to reach desired results.

The following problems may occur with Laser Genesis® treatment:

1. A slight warming sensation and some discomfort and/or pain may be experienced during treatment.
2. Short-term effects may include redness, swelling, burning, blistering, or bleeding of the treated areas. If any of these occur, please call our office.
3. During the healing process, there is a slight possibility that the treated area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent. Avoiding sun exposure before and after treatment reduces risk of color changes.
4. Treatment my result in itching and/or dry skin.
5. A temporary red rash/bumps may appear after treatment.
6. Sun exposure may increase risk of side effects and adverse effects.
7. Infection is a possibility whenever the skin surface is disrupted, although proper wound care should prevent this. Herpes simplex virus infections around the mouth can occur following a treatment for both individuals with a past history of herpes simplex virus and individuals with no known history of herpes simplex virus. Should any type of skin infection occur, additional treatments or medical antibiotics might be necessary.
8. Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the chances of scarring, it is important that you follow all post-treatment instructions.
9. Allergic reactions. In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations have been reported. Systemic reactions may result from prescription medications.
10. Protective eyewear (shields) will be provided to you during the treatment. Failure to wear eye shields during the entire treatment may cause severe and permanent eye damage.

Compliance with the aftercare guidelines is crucial for healing, prevention of scarring and hyperpigmentation.

ACKNOWLEDGEMENT:

I acknowledge that the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me
- Reasonable anticipated health consequences if the procedure is not performed
- Possible complications/risks involved with the proposed procedure and subsequent healing period

For women of childbearing age: By signing below, I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep Nurse informed should I become pregnant during the course of treatment.

I hereby authorize above named Nurse to perform Laser Genesis® treatment on me. I acknowledge that I have read and fully understand the contents of this informed consent for Laser Genesis® treatment and that all of my questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release INTERLOCKS from all liabilities associated with the above indicated procedure.

Patient Signature: _____ Date: ____ /____ /____

Nurse Signature: _____ Date: ____ /____ /____