KAROL A GUTOWSKI, MD, FACS
AESTHETIC SURGERY
CERTIFIED BY THE AMERICAN BOARD OF PLASTIC SURGERY
MEMBER AMERICAN SOCIETY OF PLASTIC SURGEONS

CONSENT for IPL TREATMENT

Patient Name: Date:

INTENSE PULSE LIGHT (IPL) TREATMENT *is a procedure that uses light to lighten, fade or remove photo-damaged skin in a non-ablative manner and is often referred to as photo rejuvenation. Light can be used to effectively destroy targets located in the skin with minimum damage to the surrounding tissue. Visible signs of photo damage include wrinkling, enlarged pores, coarse skin texture and pigment alterations.*

I AM AWARE OF THE FOLLOWING POSSIBLE SIDE EFFCTS WITH IPL/PHOTO-THERAPY:

ERYTHEMA (redness) and EDEMA (swelling) - Redness & swelling of the treated area can occur but usually subsides within a few hours but can last up to 7 days or longer. Irritation, itching, and/or a mild burning sensation or pain similar to sunburn may occur within 48 hours of treatment.

PIGMENT CHANGES (Skin Color) – Hyperpigmentation and hypopigmentation of the skin in the treated area can occasionally occur. Mostly it is transient, lasting up to six months, but in rare cases it can be permanent. Most cases of hyper- or hypo-pigmentation occur in people with darker skin or when the treated area has been exposed to sunlight before or after treatment. Occasionally these pigmentation changes occur despite appropriate protection from the sun.

SCARRING – which can be hypertrophic or even keloid, can occur. Other known complications of this procedure include: blisters, reddening, pinpoint pitted scars, bruising, superficial crusting, burns, pain, and infections. These side effects are usually temporary, lasting from five to ten days but can be permanent as well.

BRUISING – The skin at or near the treatment site may become fragile. If this happens, makeup should be avoided and the area should not be rubbed, as this might tear the skin. A blue-purple bruise may appear on the treated area, which might last from five to fifteen days. As the bruise fades, there may be rust-brown discoloration of this skin, which fades in one to three months or longer.

HAIR LOSS – There is a known and expected loss of hair in the treated areas. In a very small percent of people there is new hair growth in the surrounding areas being treated.

EYE DAMAGE –Eye damage can occur from the light and therefore protective eyewear must be worn during all phototherapy sessions.

Acknowledgements:

- *I UNDERSTAND THAT EVEN THOUGH APPROPRIATE MEASURES ARE TAKEN TO REDUCE SIDE EFFECTS, THEY CANNOT BE COMPLETELY ELIMINATED IN EVERY CASE. I UNDERSTAND THAT THE TREATMENT MAY INVOLVE RISKS OF COMPLICATION OR INJURY FROM BOTH KNOWN AND UNKNOWN CAUSES, AND I FREELY ASSUME THESE RISKS.*

- *I UNDERSTAND THAT THERE MAY BE OTHER TREATMENT OPTIONS, SUCH AS INJECTIONS OR PEELS, AND OTHER TYPES OF LASERS/LIGHT SOURCES. WITH THIS IN MIND, I AM CHOOSING THIS NON-INVASIVE TREATMENT FOR VASCULAR AND/OR PIGMENT LESION AND OTHER INDICATED SKIN CONDITIONS.*

- *I HAVE READ AND UNDERSTAND THE PRE AND POST-TREATMENT INSTRUCTIONS. I AGREE TO FOLLOW THESE INSTRUCTIONS CAREFULLY. I UNDERSTAND THAT COMPLIANCE WITH RECOMMENDED PRE AND POST PROCEDURE GUIDELINES ARE CRUCIAL FOR HEALING, PREVENTION OF SCARRING, AND OTHER SIDE EFFECTS AND COMPLICATIONS SUCH AS HYPERPIGMENTATION, HYPOPIGMENTATION, AND OTHER SKIN TEXTURAL CHANGES.*

- *I UNDERSTAND THAT THIS EXAMINATION IS NOT MEANT TO REPLACE THE NECESSITY FOR A COMPLETE DEMATOLOGICAL EXAMINATION.*

- *I UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY REPONSIBLE FOR PAYMENT.*

- *I UNDERSTAND THAT NO GUARANTEE, WARRANTY, OR ASSURANCE HAS BEEN MADE TO ME AS TO THE RESULTS THAT MAY BE OBTAINED. I AM AWARE THAT FOLLOW-UP TREATMENTS MAY BE NECESSARY FOR DESIRED RESULTS. MOST PATIENTS REQUIRE A NUMBER OF TREATMENTS OVER SEVERAL MONTHS WITH GRADUAL RESULTS OCCURRING OVER THIS TIME. CLINICAL RESULTS WILL VARY PER PATIENT. I AGREE TO ADHERE TO ALL SAFETY PRECAUTIONS AND REGULATIONS DURING THIS TREATMENT. NO REFUNDS WILL BE GIVEN FOR TREATMENTS RECEIVED.*

- *PHOTOGRAPHS: I GIVE PERMISSION FOR MY PHOTOGRAPHS TO BE USED TO HELP DOCUMENT MY TREATMENT COURSE. CONFIDENTIALITY WILL BE MAINTAINED.*

- *THE NATURE AND PURPOSE OF THE TREATMENT HAVE BEEN EXPLAINED TO ME. I HAVE READ AND UNDERSTAND THIS AGREEMENT. ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACATION AND I CONSENT TO THE TERMS OF THIS AGREEMENT. ALTERNATIVE METHODS OF TREATMENT AND THEIR RISKS AND BENEFITS HAVE BEEN EXPLAINED TO ME AND I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TREATMENT.*

I hereby give my consent and authorization voluntarily, and release

Karol A Gutowski, MD LLC & AFRESH MED SPA and its employees from any claims implied or understood that I have or may have in the future, connected with this treatment, regardless of result(s). I am stating that I fully understand the above precautions, and the treatment was fully explained to me in detail, along with all the risks and benefits. I will notify the office of any adverse effects immediately, and also certify, that if any changes occur in my medical history/health or regime I will notify the office as soon as possible.

Patient (Print Name)	Signature	Date
Witness (Print Name)	Signature	Date