CONSENT for CO2 Laser Treatment

INSTRUCTIONS
This is an informed-consent document which has been prepared to help inform you about resurfacing procedures of the skin including alternative treatments and risks.

It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for surgery as proposed by your plastic surgeon(s).

A **CARBON DIOXIDE LASER** treatment is used for skin resurfacing. Thin layers of skin are vaporized using a high-energy beam of laser light. This creates a "controlled injury" to the skin: as the skin heals, it produces collagen as a natural part of the healing process, which restores your skin's elasticity.
CO_2 laser resurfacing is designed to minimize wrinkles, reduce facial scarring, even out skin tone, and increase dermal collagen.

ALTERNATIVE TREATMENT
Alternative forms of treatment include not undergoing the proposed skin resurfacing procedure. Other forms of management include chemical peels, dermabrasion, or surgical procedures, such as excisional surgery. In certain situations, the laser may offer a specific therapeutic advantage over other forms of treatment. Alternatively, laser resurfacing procedures may not represent a better alternative to other forms of surgery or skin treatment when indicated. Risks and potential complications are associated with alternative forms of treatment that involve skin resurfacing(s) or surgical procedures.

RISKS OF LASER RESURFACING ARE AS FOLLOWS:
Every procedure involves a certain amount of risk, and it is important that you understand the risks involved. An individual's choice to undergo a procedure is based on the comparison of the potential risks to benefits. Although most patients do not experience the following complications, you should discuss each of them with your plastic surgeon(s) to make sure you understand the risks, potential complications, and consequences of laser resurfacing treatment.

INFECTION - Although infection following skin treatment is unusual, bacterial, fungal, and viral infections can occur. Herpes simplex virus infections around the mouth, can occur following a resurfacing treatment. This applies to both individuals with a past history of Herpes simplex virus infections and individuals with no known history of Herpes simplex virus infections in the mouth area. You will be given a prescription for Valtrex (antiviral) to be taken prior to treatment to suppress a potential infection from this virus. Should any type of skin infection occur, additional treatment including antibiotics may be necessary.

SCARRING - Although normal healing after the procedure is expected, abnormal scars may occur both in the skin and deeper tissues. In rare cases, keloid scars may result. Scars may be unattractive and of different color than the surrounding skin. Additional treatments may be needed to treat scarring.

Patient Initials: _______

BURNS- Laser energy can produce burns. Adjacent structures including the eyes may be injured or permanently damaged by the laser beam. Burns are rare; if a burn does occur, additional treatment may be necessary to treat laser burns.

BLISTERS - It is common for treated areas to develop blisters. It is important to keep skin clean and moist during this time.

PEELING- It is common for treated areas to peel. Once skin begins to peel it will generally turn dark. Do not pick at skin; It is important to allow skin to heal on its own.

COLOR CHANGE - Resurfacing may potentially change the natural color of your skin. Skin redness usually lasts 1-3 months and occasionally 6 months following laser skin resurfacing. There is the possibility of irregular color variations within the skin including areas that are both lighter and darker. A line of demarcation between normal skin and treated skin can occur.

ACCUTANE (isotretinoin) - Accutane is a prescription medication used to treat certain skin diseases. This drug may impair the ability of skin to heal following treatments or surgery for a variable amount of time even after the patient has ceased taking it. Individuals who have taken this drug are advised to allow their skin at least 6 months to recover from Accutane before undergoing skin treatment procedures.

BLEEDING – depending upon the depth of treatment, pinpoint bleeding is common.

SKIN TISSUE PATHOLOGY - Laser energy directed at skin lesions may potentially vaporize the lesion. Laboratory examination of the tissue specimen may not be possible.

VISIBLE SKIN PATTERNS - Treatment procedures may produce visible patterns within the skin. The occurrence of this is not predictable.

PAIN - Very infrequently, chronic pain may occur after skin resurfacing procedures.

DELAYED HEALING - It may take longer than anticipated for healing to occur after treatments. Skin healing may result in thin, easily injured skin. This is different from the normal redness in skin after a treatment. It is important to follow the post treatment guidelines given to you to insure optimal healing. Smokers have a greater risk of skin loss and wound healing complications.

ALLERGIC REACTIONS - In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations have been reported. Systemic reactions which are more serious may result from drugs used during surgery and prescription medicines. Allergic reactions may require additional treatment.

DAMAGED SKIN - Skin that has been previously treated with chemical peels, lasers, or dermabrasion, or damaged by burns, electrolysis (hair removal treatments), or radiation therapy may heal abnormally or slowly following treatment by lasers or other surgical techniques. The occurrence of this is not predictable. Additional treatment may be necessary.

Patient Initials: _______

SKIN CANCER/SKIN DISORDERS - Skin resurfacing procedures may not offer protection against developing skin cancer or skin disorders in the future.

DISTORTION OF ANATOMIC FEATURES - Skin treatments can produce distortion of the appearance of the eyelids, mouth, and other visible anatomic landmarks. The occurrence of this is not predictable. Should this occur, additional treatment including surgery may be necessary.

PATIENT FAILURE TO FOLLOW POST TREATMENT GUIDLINES – Following post treatment guidelines after a skin resurfacing procedure is important. Guidelines concerning appropriate restriction of activity, use of dressings, and use of sun protection need to be followed to avoid potential complications, increased pain, and unsatisfactory results. It may be recommended that you utilize a long-term skin care program to enhance healing following a skin resurfacing.

UNSATISFACTORY RESULT - There is the possibility of an unsatisfactory result from these procedures. Resurfacing procedures may result in visible deformities, skin slough, loss of function, and permanent color changes in the skin. You may be disappointed with the final result from laser resurfacing.

LACK OF PERMANENT RESULTS - Resurfacing treatments may not completely improve or prevent future skin disorders, lesions, or wrinkles. No technique can reverse the signs of skin aging. Additional surgical procedures may be necessary to further tighten loose skin.

SURGICAL ANESTHESIA - Both local and general anesthesia involve risk. There is the possibility of complications, injury, and even death from all forms of surgical anesthesia and sedation.

DEATH OR SERIOUS INJURY - In very rare cases, serious complications such stroke, heart attack or even death have resulted from surgery.

UNKNOWN RISKS - There is the possibility that additional risk factors of laser skin resurfacing may be discovered. The results of performing skin tightening surgery and resurfacing are unknown in terms of the combination effect of the two procedures and potential complications, depending on the area treated. Skin slough, delayed healing and poor surgical outcome may occur.

FIRE - Inflammable agents, surgical drapes and tubing, hair, and clothing may be ignited by laser energy. Laser energy used in the presence of supplemental oxygen increases the potential hazard of fire. Some anesthetic gases may support combustion.

LASER SMOKE (plume) - Laser smoke is noxious to those who encounter it. This smoke may represent a possible biohazard.

Patient Initials: _______

ADDITIONAL TREATMENT OR SURGERY NECESSARY

There are many variable conditions which influence the long-term result of laser skin treatments. Even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with these procedures. Other complications and risks can occur but are even more uncommon. Should complications occur, additional surgery or other treatments may be necessary. The practice of medicine and surgery is not an exact science. Although good results are expected, there is no guarantee or warranty expressed or implied on the results that may be obtained.

FINANCIAL RESPONSIBILITIES

The cost of skin resurfacing involves several charges for the services provided. This includes fees charged by your doctor, the cost of pre and post treatment skin care medications, surgical supplies, equipment and personnel, and possible outpatient hospital charges, depending on where the procedure is performed. It is unlikely that cosmetic surgery costs would be covered by an insurance plan. Even if there is some insurance coverage, you will be responsible for necessary co-payments, deductibles, and charges not covered. Additional costs may occur should complications develop from the surgery. Secondary surgery or hospital day-surgery charges involved with revisionary surgery or treatments would also be your responsibility.

DISCLAIMER

Informed consent documents are used to communicate information about the proposed treatment of a condition along with disclosure of risks and alternative forms of treatment(s). The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances.

However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered.

Informed consent documents are not intended to define or serve as the standard of medical care. Standards of medical care are determined based on all the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

<u>It is important that you read the above information carefully and have all your questions answered before signing the consent on the next page.</u>

Patient Initials: _______

CONSENT FOR SURGERY, PROCEDURE OR TREATMENT

1. I hereby authorize Dr. Karol Gutowski and/or Dr. Andrea Martin, and such assistants as may be selected, to perform laser skin resurfacing.

   I have received and read the following information sheets:
   - CONSENT FOR CO2 LASER TREATMENT
   - CO2 PRE-TREATMENT GUIDELINES
   - CO2 POST-TREATMENT GUIDELINES

2. I recognize that during the medical treatment, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above physician(s) and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my physician(s) at the time the procedure is begun.

3. I consent to the administration of such anesthetics considered necessary or advisable. I understand that all forms of anesthesia involve risks, and the possibility of complications, or injury.

4. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.

5. I consent to the photographing and video recording of the operation(s) or procedure(s) to be performed, including appropriate portions of my body, for medical, scientific or educational purposes, provided my identity is not revealed by the pictures.

6. For purposes of advancing medical education, I consent to the admittance of observers to the operating room.

7. I consent to the disposal of any tissue, medical devices or body parts which may be removed.

8. I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical-device registration, if applicable.

9. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
   a. THE ABOVE TREATMENT OR PROCEDURE TO BE UNDERTAKEN
   b. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT.
   c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-9). I AM SATISFIED WITH THE EXPLANATION.

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Patient (Print Name) Signature Date

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Witness (Print Name) Signature Date

AUTHORIZATION & CONSENT FOR RELEASE OF MEDICAL IMAGES

It is important that you read this information carefully and completely. After reviewing, please sign the consent as proposed by The Physicians or their representatives.

INTRODUCTION

For your medical records, images (photographs, slides, videos, interviews or any other images of you, or components of your medical record) may be taken before, during, or after a surgical procedure or treatment. These images may be needed to document your medical condition, used as supporting material for authorizing medical coverage and payments, and treatment planning. Consent is required to take, use and release such images. Since The Physicians are also educators of other physicians, researchers, and healthcare providers, your images may be used for other purposes as described below.

1. **CONSENT TO TAKE PHOTOGRAPHS, SLIDES, DIGITAL IMAGES, AND VIDEOGRAPHY**
   I hereby authorize The Physicians and/or their associates to take any images before, during and after my treatments or surgeries.

2. **CONSENT FOR RELEASE OF PHOTOGRAPHS/SLIDES/ VIDEOGRAPHY**
   I hereby authorize The Physicians and their associates to use any of these images for professional medical purposes deemed appropriate including but not limited to showing these images on public or commercial television, electronic digital networks including the internet, print or visual or broadcast media, for purposes of examination, testing, credentialing and/or certifying purposes for medical education, patient education, lay publication, or during lectures to medical or lay groups, for marketing and advertising, and for use in medical teaching, research or dissemination of medical information to medical and nonmedical audiences, including, but not limited to, journal or book publications, presentations, conferences, and print marketing material (magazine, newspaper, etc.) or electronic media (television, internet, etc.)

3. **CONSENT FOR RELEASE TO PROFESSIONAL ORGANIZATIONS**
   I further authorize The Physicians and their associates to release such images to the American Society of Plastic Surgeons (ASPS), the American Society for Aesthetic Plastic Surgery (ASAPS), the American Board of Plastic Surgery (ABPS), the American Academy of Facial Plastic and Reconstructive Surgery (AAFPRS), and the American Board of Facial Plastic and Reconstructive Surgery (ABFPRS). I provide this authorization as a voluntary contribution in the interests of public education. The images may be used for publication in print, visual or electronic media, specifically including, but not limited to, medical journals (such as Plastic and Reconstructive Surgery, Annals of Plastic Surgery, Aesthetic Plastic Surgery), textbooks, lay publications, patient education or during lectures for the purpose of informing the medical profession or the general public about plastic surgery methods, medical education or examination material by ASPS, ASAPS, ABPS, AAFPRS and ABFPRS. I understand that such images shall become the property of ASPS, ASAPS, ABPS, AAFPRS and ABFPRS and may be retained or released by these organizations for the limited purpose mentioned above. I also grant permission for the use of any of my medical records including illustrations, photographs, video, or other imaging records created in my case, for use in examination, certifying and/or re-certifying purposes by ABPS and ABFPRS.

   I understand that I will not be identified by name in any release of these materials but in some cases the images may contain features that may make my identity recognizable. I release and discharge The Physicians and all parties acting on their authority from all rights that I may have in these images, and from any claims that I have related their use in the above-mentioned manner.

   I also release The Physicians and any employees or agents from all liability, including any claims of libel or invasion of privacy, directly or indirectly connected with, arising out of, or resulting from the taking and authorized use of these images or recorded interviews.

   I understand that I have the right to request cessation of recording or filming at any time. I understand that I will not be entitled to monetary payment or any other consideration as a result of use of these images and /or my interview.

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Patient (Print Name) Signature Date

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Witness (Print Name) Signature Date

Patient Initials: _______