Dermatology Office, Ellen Turner MD

FRACTIONAL PHOTOTHERMOLYSIS TREATMENT CONSENT

Dr. Ellen Turner or her staff has explained to me that I appear to be an appropriate candidate for Fraxel laser skin treatment and that although Fraxel laser treatment has been shown to be effective, no guarantee can be made that I will benefit from treatment or that it will be without complications. I understand the limitations of Fraxel laser treatment and the importance of adherence to the prescribed series schedule. I understand that common side effects and complications of this procedure include:

- PAIN. During the procedure, there is mild to moderate discomfort, similar to a stinging sensation. Topical anesthetic cream is applied to reduce pain during the treatment. Oral analgesics may be prescribed before and/or after the procedure as needed for comfort.
- SWELLING. Areas likely to swell are around the eyes. This will typically subside within hours to days. Frequent ice application will reduce swelling.
- REDNESS. Treated areas typically appear pink for 3-7 days, but can usually be covered with makeup.
- ALLERGIC REACTION. An allergic reaction to a topical cream or anesthetic may occur. This will be treated as appropriate.
- SKIN PIGMENTARY CHANGE. A temporary darkening of the treatment area may occur- particularly in patients with darker skin tones. Appropriate creams may be prescribed as needed.
- REACTIVATION OF COLD SORES. If you have a history of cold sores, laser treatment (particularly around the mouth) could cause them to reoccur. It is, thus, imperative that you advise your physician if you have ever experienced a cold sore. Proper precautions to prevent and/or treat an outbreak should be taken.
- BRONZING. A bronzed appearance to the skin may occur and typically lasts 3-14 days.
- FLAKING. Flaking can occur after treatment similar to that of a sunburn.
- INFECTION. An infection in the post-operative period may result. This risk is minimized with good skin care, including frequent hand-washing. If an infection is suspected, call the office immediately to ensure that proper therapy is initiated.
- BLISTERS OR SCABS. Blisters or scabs may occur and take several weeks to resolve. Areas of blistering may result in a scar.

(Initial) _________ I have no history of cold sore, fever blisters, or shingles. (Circle as appropriate)

(Initial) _________ I do have a history of cold sore, fever blisters, or shingles. (Circle as appropriate)

* By providing my signature below and initialing above, I acknowledge that I have read and understood all of the information outlined in this consent form.
* I have had all of my questions answered to my complete satisfaction.
* I understand that a series of treatments are typically necessary in order to enhance clinical results.
* I acknowledge that no guarantee or assurance has been made to me by my physician or medical staff member regarding the results that may be obtained and those results vary by individual.
* I freely consent to the Fraxel laser treatment as prescribed by my physician.

_____* I understand that my final result may be no result

_____* NO REFUND

I understand my photos will be used to track my treatment progress and also permit their use for medical publication and teaching purpose, as well as marketing purposes. I hereby authorize Ellen Turner, M.D. and her associates or licenses to use pre-operative, intra-operative, and post-operative photographs, slides, and/or videotapes for professional medical purposes including, but not limited to showing these images on public or commercial television, electronic digital network/websites, or the purpose of patient education, lay education or during a lecture to medical or lay groups. I acknowledge that no guarantee or assurance has been made to me by Dr. Turner or her medical staff regarding the results that may be obtained.
I do_____ I do not_____ give permission for my photographs, closely cropped to be used further by the physician for educational purposes.

Patient Signature: ____Date: __________

Witness Signature: ____Date: __________

Doctor Signature: ____Date: __________