

## ULTRASONIC FACIAL TREATMENT INFORMED CONSENT FORM

1. I understand that all items contained herein apply to the following procedure(s): **Ultrasonic Facial Treatment**. The purpose of Ultrasonic treatments is to help improve the tone and texture of my skin through superficial removal of dead skin cells thus giving it a youthful glow.
2. **NO RESULTS GUARANTEED** - I understand that Ultrasonic treatments are a cosmetic procedure that is not an exact science and that no guarantee of outcome can be made.
3. **Pain** is the most important determinant to prevent burns and other adverse events during the procedure. If your pain is more than 4 on a scale of 10, you must ask the staff to STOP the procedure. Pain scale - 1 being the least and 10 being the worst pain you have ever had.
4. I understand that although rare, certain risks or complications could occur but are usually treatable and temporary, such as hyper pigmentation (darkening of the skin), hypo pigmentation (lightening of the skin), and scarring. Following all pre & post procedure instructions will help avoid conditions.
5. I acknowledge that if I am prone to Herpes (cold sores, fever blisters) that I may need a prescription for Valtrex (acyclovir) from my physician prior to having Ultrasonic treatments. I need to avoid treatments during a breakout.
6. I acknowledge that I have not used Accutane during the last 3 months. I acknowledge that I should avoid the use of skin lighteners and amino acid glycolic Retin-A type products 2 days before and 2-4 days after treatment or until all pinkness has subsided.
7. **Photographs** –
  - I authorize the taking of photographs or videotapes, or other similar means of recording the treatment.
  - I understand that my privacy will be protected and will in no way reveal patient identity
  - I understand that these recordings may be used for documenting progress of my treatment and outcomes, illustrating the medical procedure, medical study, research, publication and marketing.
  - I give permission to use and publish the same in whole or in part, individually or in conjunction with other photographs, in any medium for any purpose, including art, illustration, promotion, advertising or trade
  - Failure to allow the taking of photographs of my treatments will make it impossible to judge the efficacy of my treatments and will void any extended treatment program, guaranty and/or any treatment beyond those included in the purchased package.
  - I give permission to American Laser Center to copyright the same in their name or any other name that they may choose
  - I hereby release ALC and its agents from any and all claims and demands arising out of, or in conjunction with the use of the photographs

I certify that I have read this entire consent and I agree to all the information presented to me in the clinic and in this consent form & the pre/post procedure instructions. A member of the ALC staff has explained the following:

- No results are guaranteed.

- Nature of my condition and nature of the procedure
- Alternative procedures
- The potential benefits & what to reasonably expect after undergoing this procedure & limitations
- The complications, risks and contraindications of this procedure
- Benefits of this procedure over the alternatives
- I have had ample opportunity to ask any questions regarding the procedure, side effects and after care, and all of my questions have been answered to my satisfaction. I believe I have adequate knowledge to understand the nature and risk of the treatment to which I am consenting.
- Upon request, I have been given copies of the consent and pre/post care instructions.

I agree that this consent supersedes any previous verbal or written disclosures. This consent is valid for all my **Ultrasonic Facial Treatment** in the future as well.

Patient/Legal Guardian Signature \_\_\_\_\_  
Date \_\_\_\_\_