The Center for Facial Plastic Surgery

Ali Sepehr, MD

CO2 FRACTIONAL SKIN REJUVENATION INFORMED CONSENT

PATIENT CONSENT TO TREATMENT

1. I, _____, consent to and authorize members of the staff at The OC Center for Facial Plastic Surgery to perform a treatment of fractional CO2 laser on me. The areas to be treated are limited to _____.
   I understand that the purpose of this procedure (CO_2 Laser Resurfacing) is for _____.
2. The nature and purpose of the treatment have been explained to me, and my questions have been answered to my satisfaction. **I realize that darkening or lightening of the treated skin may occur, at times lasting many months following treatment. I also realize that other possible complications include superficial erosions, bruising, blistering, redness, swelling, activation of cold sore virus, and the rare possibility of permanent scarring. I understand that the possible risks of the procedure include crusting, pain, purpura, swelling, redness, bruising, scarring, blistering, hypopigmentation, hyperpigmentation, mottling of skin vascularity and pigmentation and unforeseen complications. Eye injury is possible but unlikely, providing complete eye protection is properly used throughout laser treatment.** Color changes, such as hyperpigmentation (brown/red discoloration) or hypopigmentation (skin lightening), may occur in treated skin. This may take several months to resolve, if at all. Unprotected sun exposure in the weeks following treatments is contraindicated as it may cause or worsen this condition. Blistering of the skin may occur. Scarring happens but is uncommon.
3. I understand that topical anesthetics may be used. I understand that I must wear the protective goggles at all times during actual treatment.
4. I understand that the treated area requires specific cleansing and care, and sunscreen or sunblock must be used 6 weeks after treatment. I agree to follow post procedure instructions to minimize the risk of problems.
5. I understand that the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume those risks. There are several alternatives to treatment including but not limited to other laser treatments, chemical peels, RF treatments, or no treatment at all.
   Alternative means of treatment and their risks and benefits have been explained to me, and I understand that I have the right to refuse the procedure. I am also aware that this treatment is not as invasive as a CO2 resurfacing treatment, but also may not have the same dramatic results as a more invasive treatment.
6. I certify that I have read this entire Informed Consent and that I understand and agree to the information provided in this form. I have been asked at this time whether I have any questions about this procedure and do not. I understand the procedure, and risks, accept the risks, and request that this procedure be performed on me by the doctor or other qualified staff.
   I certify that I am a competent adult of at least 18 years of age. I understand that if I am a minor under the age of 18, the consent of my parent or legal guardian will also be required before treatment. This Informed Consent is freely and voluntarily executed and shall be binding upon my spouse, relative, legal representatives, heirs, administrators, successors, and assigns. I agree that any pictures taken of my treatment site may be used for publication or teaching purposes, however, my name will not be disclosed and complete confidentiality will be maintained. I further agree that any pictures or videotape taken of me may be used for either teaching or publication, if considered appropriate; unless I notify the doctor in writing that he or she is not to use these photographs prior to publication.
7. I understand the treatment may be painful, but this is typically manageable without any pain relief medication.
8. I realize that no guarantee, warranty, or assurance has been made as to the treatment results.
9. I agree to adhere to all safety precautions and regulations during the laser treatment.
10. I agree to pay $_____ for the treatment.

Patient Name (Please Print) _____
Patient Signature _____ Date_____
Witness Name (Please Print) _____
Witness Signature _____ Date_____
Signature of Practitioner _____ Date_____