BRIDGEPORT LASER & WELLNESS CENTER
Pixel 2940 nm Erbium Laser
CONSENT FORM

Please read and initial each statement.

_____ I have read the Pixel 2940nm Erbium Laser Information and Instruction sheet and have had an opportunity to ask questions about the procedures and treatment.

_____ I authorize the physician, nurse or laser technician to perform PIXEL fractional ablative laser resurfacing on me.

_____ The cost of the procedure(s) has been discussed with me and I agree to pay this amount.

I understand:

_____ • the goal of PIXEL is the gradual improvement of skin texture. Every individual is unique which makes it difficult to guarantee a specific number of treatments needed. Results vary with the individual depending on skin color, degree of sun damage or textural issues being treated. It is expected I may require 3 - 6 treatments to see improvement. Although good results are expected it is impossible to guarantee.

_____ • expected side effects of Pixel treatment includes redness, burning sensation, tightness and flaking of skin. These should resolve over 1-3 days but may last longer. Infrequent complications of a Pixel treatment include blistering, infection, bruising or discoloration that are usually temporary. Rarely, scarring and permanent discoloration can occur. Hair loss may also be an inadvertent side effect that may or may not be permanent. There may be risks not yet known at this time.

_____ • every person is unique and although good results are expected, it is impossible to guarantee.

_____ • side effects are worsened by sun exposure and use of a good quality SPF product daily is very important and highly recommended.

_____ • there may be an increased occurrence of side effects if I do not follow the post procedure instructions.

_____ • PIXEL treatments are not recommended if you are pregnant or breastfeeding, if you have active infection or tattoos at the site, if you are taking photosensitizing agents such as Accutane or Gold therapy and/or certain herbal medications such as St John's Wort or Ginkgo Biloba, unwilling to wear SPF products, have tattoos in the area to be treated, have a history of light sensitive seizures, keloid formation, melasma. None of these conditions apply to me and if they do I am at increased risk of side effects.

_____ • eye damage may occur if protective eyewear is not worn.

_____ • there are other options for treatment including not having the procedure.

_____ • the risk of side effects increases with other medical conditions such as immuno-compromised conditions (diabetes, HIV, smoking, being on immune suppressants such as prednisone) that can be associated with poor skin healing and increased risk of infection. None of these conditions apply to me.

I authorize the taking of clinical photographs for:

√ my clinic record
☐ research and education (discretion applied)
☐ publication
☐ the WLMS or BPWC website (discretion applied)
☐ the Before & After Book kept in the clinic (discretion applied)

I have read and understand this Pixel 2940nm Erbium Laser Consent Form. My questions have been answered satisfactorily by the doctor, nurse or laser technician. I accept the risks and complications of the procedure.

Patient Name (print)	Patient Signature	Date