2826 OLD LEE HIGHWAY, SUITE 250 FARFAX VA 22013
(703)854-1298

CONSENT FOR LASER/LIGHT BASED TREATMENT

I authorize the dedicated staff at Carelife Style Medical Aesthetics to perform Laser/pulsed light Cosmetic treatment on me including, but not limited to deep tissue heating, hair removal, treatment of pigment lesions, acne, wrinkles, tattoo removal and vascular lesions. I understand that the procedure is purely elective, that the results may vary with each individual, and multiple treatments may be necessary.

I understand: Serious complications are rare, but possible. Common side effects include temporary redness and mild "sunburn" like effects that may last a few hours to 3-4 days or longer. Pigment changes, including hypopigmentation (lightening of the skin) or hyperpigmentation (darkness of the skin), and lasting 1-6 months or longer may occur. In addition, freckles may temporarily or permanently disappear in treated areas. Other potential risks include crusting, itching, pain bruising, burs, infection, scabbing, scaring, swelling, and failure to achieve the desired result. Lasers/intense light can cause eye injury and protective eyewear must be worn during treatment.
I understand that a series of treatments may be required to achieve the desired result.

I understand that sun or tanning lamp exposure and not adhering the post-care instructions provided to me may increase my chance of complications.

I consent to photographs being taken to evaluate treatment effectiveness, foe medical education, training, professional publications or sales purposes. Photographs revealing my identity my identity will not be used without my written consent. If my identity is not revealed, theses photographs may be used and displayed publicly without my permission.

Before and after treatment instructions have been discussed with me. The procedure as well as the potential benefits and risks have been explained to my satisfaction. I have had all my questions answered. I freely consent to the proposed treatment.

Laser Treatment Performed:

Laser Genesis Procedure _____
Pico Genesis Procedure _____
Laser Hair Removal Procedure _____
Acne Treatment Procedure _____

Rosacea Procedure _____
Titan Procedure _____
Vascular and Pigmented Lesion Procedure _____
Facial Veins/Angiomas Treatment Procedure _____
Resurfacing Treatment Procedure _____
Warts and Skin Tag Treatment Procedure _____
Tattoo Removal Treatment _____

Patient Signature _____ DATE _____

Print Name _____

Witness Signature _____ Date _____

Print Name _____