



Beauty, laser & wellness center
Monica Bonakdar, MD

Fraxel Laser Treatment Consent Form

This form is designed to provide you with the information you need to make an informed decision on whether or not to have the Fraxel treatments performed. If you have any questions or do not understand any part of this consent, please do not hesitate to ask us.

TREATMENT- I have requested treatment on the following areas:

Face Neck Chest Hands Arms Other _____

Fraxel Laser treatment is FDA cleared for correction of wrinkles and lines, correction of pigmented lesions including age spots and skin discoloration, resurfacing the skin, correction of melasma, acne scar and surgical scar correction.

_____ I understand that a single procedure will not remove all my skin problems completely and that optimal results may require multiple treatments.

_____ I understand that each individual's response will vary according to their skin type, area being treated, and their follow up care.

_____ I understand that post treatment skincare products to heal my skin are required at an additional cost.

CONTRAINDICATIONS-

- I do not have diabetes, autoimmune disorder, or history of cold sores..
- I am not pregnant and I am not breastfeeding.
- I am not using Accutane nor have I been on Accutane in the last year.
- I do not have a history of keloid scar formation or poor wound healing.
- I do not have allergies to Lidocaine or Tetracaine.

HERPES SIMPLEX- Herpes simplex eruption may result in rare cases in a treated area that has previously been infected with the virus. This reactivation can be avoided by taking an Anti-viral prior to the procedure. . I understand that if I have ever, in my life, experienced a cold sore in the area of my treatment, I must start on an antiviral prophylaxis and I can get a prescription from this office by requesting the medication.

SIDE EFFECTS- Just as there may be benefits to a procedure, I understand that all procedures involve risks to some degree.

Bluish Tint to the Skin- A blue dye will be applied to skin prior to laser treatment which will be removed post treatment. Often a slight dye residue will remain on the skin, especially in areas

with dryness. This will fade over the first several days and will slough off during the peeling process.

Pain- Some patients feel discomfort during the treatment for which a topical anesthetic cream will be applied prior to the treatment. Additional topical anesthetic cream will be applied just prior to the treatment. In addition, the Zimmer cooler (a device which blows cold air onto the skin) will be used during the treatment for additional cooling to alleviate any discomfort. A mild burning sensation may last for the first several days post treatment.

Redness and Swelling- Immediately after your treatment your skin will be red and feel hot. This is temporary and not harmful but may last for the first several days. The first day after your treatment and for the next several days your skin will continue to be red and become swollen. Cold packs may reduce these symptoms as will daily use of an antihistamine until they resolve.

Pigment Changes- The treated areas will probably heal without any pigment changes. However there is always the chance that hyperpigmentation (darker) or hypopigmentation (lighter) areas may occur. These are temporary and will fade within 1-6 months. Avoid sun exposure before and after treatment as exposure to the sun may intensify the pigment changes. It is rare that a change is permanent.

Blistering or Scarring- Blistering occurs occasionally and needs to be reported to the office for additional post care instructions. Scarring is very rare and can be avoided by following all the post-treatment instructions carefully.

Infection: This is rare following treatment if proper skin care is used after the procedure.

AUDIO AND VIDEO RELEASE- Pre and Post-Treatment photos, video and audio may be taken of the treatment for record purposes. I understand that these photos will be the property of Dr. Bonakdar. These photos may be used for diagnostic, educational, advertising, or record keeping purposes; however the material will not contain my name or any other personal identifying information.

NO GUARANTEES- Because all individuals are different, it is not possible to completely predict the benefits from this treatment. By signing this form I acknowledge that guarantees as to the final results of my treatment have not been made. Some individuals will have a very noticeable improvement after the first treatment, while others may have little or no improvement. I understand that additional treatments for additional fees may be needed to achieve my desired end result.

NO REFUNDS- This office has a strict no refund policy. This means that no refunds are given on procedures performed for any reasons.

By my signature, I acknowledge that I have read the foregoing informed consent form and have been adequately informed of the nature of my condition, the nature of the procedure, the expected benefits of this treatment, the risks of this treatment, the alternative methods of treatment, and the risks of not treating my condition. I hereby consent to this procedure.

Patient's Signature _____ Date _____

Staff Signature _____ Date _____