beauty, laser & wellness center
Monica Bonakdar, MD

FX Laser Resurfacing Informed 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 Active FX and or Deep FX 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 _____

Active FX and Deep FX Laser treatment are FDA approved procedures. Active FX resurfaces the skin and corrects pigmented lesions and fine lines. Deep FX resurfaces the skin deeper and corrects wrinkles and scars.
_____I understand that a single procedure will not remove all my skin problems completely and that optimal results may require multiple treatments three to twelve months apart.
_____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.

Pain and Itching- During treatment, pain is controlled with pre treatment of the skin with topical anesthetic cream and pre medication with oral pain and anxiety relievers. In addition,

the Zimmer cooler (a device which blows cold air onto the skin) is used during the treatment for additional cooling to alleviate discomfort. A mild burning sensation will start after the treatment and lasts for the first several days post treatment. When this discomfort subsides temporary itching sensation and swelling will occur for several days.

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. Redness, bruising and changes in skin vascularity have also been observed occasionally. These are usually 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.

Crusting, Blistering or Scarring- Crusting is part of the healing process. 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.

Scarring: There is a small chance of skin scarring because of the heat delivered to the skin. The types of possible scars include raised scars or slightly depressed scars.

Altered Sensation: There may be altered sensation of transient or permanent nerve damage at the treatment site. However, this is extremely unlikely because the system has been designed to deliver a controlled application of energy to the tissue.

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 if 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_____