

**DISCLOSURE AND CONSENT MULTILIGHT PHOTODERM  
Vasculight (DL), Pigmented Lesions (PL), Vascular Lesions (VL)**

You have the right, as a patient, to be informed about your condition and the recommended procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I (We) understand that the following surgical, medical and / or diagnostic procedures are planned for me and I (We) voluntarily consent and authorize these procedures: **Multilight Vasculight DL and /or Photoderm PL,VL**

I (We) understand the goal of this therapy, as in any cosmetic procedure, is aesthetic improvement, not perfection. The light wavelength, exposure duration and energy levels are chosen to selectively damage targeted blood vessels or pigmented lesions with minimal damage to the surrounding tissue. The intense pulsed light and/or intense pulsed laser energy is absorbed by the blood vessel, resulting in the heating of that vessel. The blood vessel walls are damaged and the body, rendering the lesion invisible and the body absorbs the damaged vessels. The light wavelength, exposure duration and energy levels are adjusted to maximize the heating to the blood vessels and limit exposure to the surrounding tissue.

I (We) understand that the following are contraindications for treatment: active Herpes Simplex to desired treatment area, pregnancy, use of medications that increase photosensitivity, diabetes, history of keloid scarring, use of anticoagulants and history of bleeding disorders.

I (We) understand that this is one of the safest procedures available. However, medical treatment is not an exact science and the degree of improvement is variable. Occasionally there is not improvement and another form of treatment may be required. Long term complications resulting from intense pulsed light and lasers are rare.

I (We) have been informed and discussed my skin care regimen with the nurse and agree to the following: strict sun avoidance for at least one week prior and post treatment with a sunblock to be used at all times and applied several times per day, frequent use of moisturizers to the areas treated and avoidance of scratching. I (We) agree to immediately inform the nurse of any blistering or possible infections to the treated area. Absolutely, commit to no tanning bed exposure during entire treatment regimen.

I (We) understand that no warranty or guarantee has been made to me as a result or cure. Just as there may be risks and hazards in continuing my present condition without treatment, there are also risks and hazards related to the performance of the procedures planned for me. I (We) understand that the following side effects or complications may occur: mild burning, blistering, temporary bruising, infection scarring and alteration of skin pigment as well as general risks inherent in all medical procedures and anesthetic administration.

I (We) understand that this treatment may consist of multiple treatments given over several months with gradual clearing of the condition over this time with clinical results varying with different skin types. I (We) further understand the treatment involves payment for each treatment and the fee structure has been explained to me.

I consent to the treatment or procedure and I understand the above information.

\_\_\_\_\_  
Patient Name (Printed)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

I have explained to the patient the nature of the above procedure as well as the reasonably anticipated risks, potential complications and alternatives to such treatment. I believe the client understands.

\_\_\_\_\_  
Physician / Nurse Signature

\_\_\_\_\_  
Date