INFORMED GMAX PRO LASER CONSENT FORM

PATIENT NAME_____

TREATMENT SITES_____

I DULY AUTHORIZE _____ TO PERFORM A LASER TREATMENT.

I understand that the GMAX pro is a device used for hair removal, skin rejuvenation, acne treatment, wrinkle reduction, leg veins and other vascular lesion treatments, of which I am consenting to be a patient receiving the treatment.

I understand that the clinical results may vary depending on individual factors, including but not limited to medical history, skin type, patient compliance with pre- and post-treatment instructions, and individual response to treatment.

I understand that there is a possibility of short-term effects such as reddening, mild burning, temporary bruising, and temporary discoloration of the skin, as well as the possibility of rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me._____**(initial)**

I understand that treatment with the laser involves a series of treatments and the fee structure has been fully explained to me._____**(initial)**

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I have informed the staff regarding any current or past medical condition, disease, or medication taken.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education, and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Please answer YES or NO-

Are you taking accutane?_____
Are you pregnant?_____
Current or history of skin cancer/other cancer/pre-malignant moles_____

Severe concurrent medical conditions (e.g. cardiac disorders)_____
Are you on any antibiotics?_____ If YES why and which one/dose?_____
Impaired immune system_____
Diseases stimulated by light (e.g.lupus, porphyria, epilepsy)_____
Diseases stimulated by heat (e.g. herpes simplex)_____
Endocrine disorders (e.g. diabetes)_____
Surgical proedures_____
Active skin infection (e.g. psoriasis, eczema)_____
Skin disorders (e.g. keloids, abnormal wound healing)_____
History of bleeding disorders_____
Use of medications/herbs inducing photosensitivity_____
Facial laser resurfacing/deep chemical peel (last 3 months)_____
Needle epilation, waxing, or tweezing (last 6 weeks)_____
Tattoo or permanent makeup_____
Tanned skin/last exposure_____
Sapheneous insufficiency_____
Medications including topical_____
Allergies_____
Medical conditions_____

Patient signature_____**Date**_____

Witness_____**Date**_____