Patient Consent Form
Laser Treatment of Facial and Leg Veins

Name: _________________________ **Date:** __________________

I hereby authorize and direct any trained associates of All Care Laser Center to remove or lighten the appearance of dilated superficial veins. The procedure involves using a laser to coagulate the vessels and it its possible the result will be minimal or not help at all. It is not possible to make every vein disappear.

The following points have been discussed with me:
• The potential benefits of the proposed procedure
• The possible alternative procedures
• The probability of success
• The reasonably anticipated consequences if the procedure is not performed
• The most likely possible complications/risks involved with the proposed procedure and subsequent healing period, including but not limited to, infection, crusting, scarring, change in skin color, and/or blistering.
• Post treatment instructions.
I am aware of the following possible experiences/risks with Laser Surgery:

___ **DISCOMFORT** - some discomfort may be experienced during laser treatment.
___ **WOUND HEALING** - Laser surgery can result in swelling, blistering, crusting, or flaking of the treated areas, which may require one to three weeks to heal. Once the surface has healed; it may be pink or sensitive to the sun for an additional two to four weeks, or longer in some patients.
___ **BRUISING/SWELLING/INFECTION** - With some lasers, bruising of the treated area may occur. Additional, there may be some swelling noted. Finally, skin infection is a possibility although rare, whenever a skin procedure is performed.
___ **PIGMENT CHANGES** (Skin Color)-During the healing process, there is a slight possibility that the treated area can become either lighter or darker in color compared to surrounding skin. This is usually temporary but, on rare occasions, it may be permanent.
___ **SCARRING** - Scarring is a rare occurrence, but it is a possibility when the skin's surface is disrupted. To minimize the chances of scarring, it is **IMPORTANT** that you follow all post treatment instructions carefully.
___ **EYE EXPOSURE** - Protective eyewear (shields) will be provided. It is important to keep these shields on at all times during the treatment in order to protect your eyes from accidental laser exposure.
____**PRE AND POST CARE**: I understand that it is my responsibility to follow the pre and post treatment instructions given to me.
____**Photographs**: I give permission for my photographs to be used to help document my treatment course. Complete confidentiality will be maintained.

ACKNOWLEDGEMENT

I UNDERSTAND AND ACKNOWLEDGE THAT PAYMENTS FOR THE ABOVE PROCEDURE ARE NON-REFUNDABLE.

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release Lisa Ricciardelli, Debra Keating, Kristina Lerner, Elizabeth Simone, Casey Frost, Dr. Azar A. Korbey and All Care Laser Center PLLC from all liabilities associated with the above indicated procedure.

By my signature below, I certify that I have read and fully understand the contents of the permission form for the laser treatment of veins and that the disclosures referred to herein were made to me.

___________________	____________________	__________________
Signature-Patient/Guardian	**Print Name/Relationship**	**Date**
___________________	____________________	__________________
Signature-Witness	**Print Name**	**Date**