MD DIET OF TEMECULA

PATIENT INFORMED CONSENT FORM
FOR LASER GENESIS SKIN THERAPY

I hereby authorize Dr. Roland Fuertez or employees, under Dr. Fuertez's supervision to perform Laser Genesis Non-Ablative Skin Therapy on me. I understand that this procedure works on promoting vibrant and healthy looking skin by creating a thermal response in the dermis that stimulates new collagen. I understand that multiple treatments are required and it is possible the result will be minimal or not help at all.

I am aware of the following possible experiences/risks:

- DISCOMFORT – A slight warming sensation may be experienced during treatment.
- REDNESS/SWELLING/BRUISING – Short term redness (erythema) or swelling (edema) of the treated area is common and may occur. There also may be some bruising.
- SKIN COLOR CHANGES – During the healing process, there is a possibility that the treated area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- ITCHING/DRY SKIN – Treatment may results in itching and/or dry skin.
- RED RASH/BUMPS – Red rash/bumps may appear after treatment. This resolves with time.
- WOUNDS – Treatment can result in burning, blistering, or bleeding of the treated areas. If any of these occur, please call our office.
- INFECTION – Infection is a possibility whenever the skin surface is disrupted, although proper wound care should prevent this. If signs of infection develop, such as pain, heat, or surrounding redness, please call our office (951) 699-3796.
- SCARRING – Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.
- SUN EXPOSURE / TANNING BEDS / ARTIFICIAL TANNING - May increase risk of side effects and adverse events.
- EYE EXPOSURE – Protective eyewear (shields) will be provided to you during the treatment. Failure to wear eye shields during the entire treatment may cause severe and permanent eye damage.

I acknowledge the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me
- Alternative treatments such as topicals, microdermabrasion, or surgery
- Reasonably anticipated health consequences if the procedure is not performed.
- Possible complications/risks involved with the proposed procedure and subsequent healing period

For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Futhermore, I agree to keep Dr. Fuertez and staff informed should I become pregnant during the course of treatment.

Photographic documentation will be taken. I hereby do___do not___authorize the use of my photographs for teaching purposes.

ACKNOWLEDGMENT

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FOR LASER GENESIS TREATMENT, AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.

Signature-Patient or Guardian	**Print Name/Relationship**	**Date**
Signature-Witness	**Print Name**	**Date**