Consent Form For Laser Vein Removal Treatment

Patient Name	:	sandhya rani				Emirates ID	:	784-1996-9294842-7
File No	:	7	DOB	:	2023-10-09	Nationality	:	Other
Gender	:	Female	Doctor's Name	:	Shilpa Sandhya	Date	:	2023-12-30

I, sandhya rani will be undergoing a vein removal procedure that involves the use of laser application.

This consent is provided as a means of education for vein removal patients. The intent of this consent is to create an understanding between the provider and the patient as to the methods and risk involved in vein removal. It should be understood that laser ablation treatments may need to be repeated several times before complete satisfaction is achieved. No guarantees have been made to me regarding the outcome of the treatment or any improvements in my condition due to the procedure.

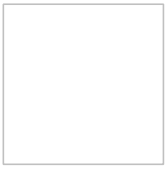
Risk

1. **Pain, burning, blister formation, and stinging sensation at the site of treatment.**
2. **Infection associated with the treatment site.**
3. **Pigmentary (color) changes at the treatment sites including decrease in skin color (hypopigmentation or lightening) and/or increase in skin color (hyperpigmentation or darkening).**
4. **Scar formation at the treated site.**
5. **Laser induced "cold sore like" blistering skin eruptions known as "herpetic" skin eruptions at the treatment site or surrounding tissue.**
6. **Poor cosmetic outcome.**
7. **Recurrence of vessels at the treated sites.**

Benefits:

1. **Lightening or removal of veins in the treatment area.**
2. **Complete removal of veins in the treatment area.**

I understand this treatment is entirely voluntary on my part. I hereby indemnify and hold harmless Australia Medical Centre and all individuals associated with Australia Medical Centre, LLC, the physician and/or the treating technician, and all staff members at the office of ss
from any and all liability, damages, cost and expenses arising from or out of the use of the Fotona Laser System. I understand that there will be a charge for this and all consecutive treatments unless arrangements have been made otherwise. I understand that I am making a decision to undergo the treatment, described in the preceding sections and I am subject to the conditions of participation described above. My below signature incdicates that I have decided to receive the treatments, having read and understood this information presented above and having been given the opportunity to ask any questions that I might have about the procedure.

Sign here, only if all of your questions have been answered to your satisfaction		
Patient	witness	Doctor
		
Patient Name sandhya rani Date 2023-12-30	Witness Name ss Date 2023-12-30	Doctor's Name Shilpa Sandhya Date 2023-12-30