Evergreen LASER
Laser Hair Removal & Med Spa

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ABLATION AND SKIN RESURFACING BY OPUS PLASMA BY ALMA LASERS CONSENT FORM

1. The Procedure I have requested that the Aestheticians under the supervision of physician at the Evergreen Laser & Med Spa perform the following procedure "*ablation and resurfacing of the skin using Opus Plasma by Alma Laser*".

2. Risks There are risks related to the performance of this Procedure. I understand and acknowledge that the risks that may occur in connection with this Procedure may include the following:
a. Discomfort, pain, rarely very superficial burn and redness of the skin – I acknowledge that I will experience some discomfort during and after the Procedure.
b. Pigment changes (skin color) – During the healing process, the treated area may become either lighter or darker in color than the surrounding skin. This is usually temporary, but on a rare occasion, it may be permanent.

3. Contraindications I acknowledge that I have been informed of certain conditions that must be met for me to have the Procedure performed.
a. Pregnancy I am not pregnant

4. No Guarantee of Success I recognize that this Procedure is not an exact science and I acknowledge that no guarantees or assurances have been made to me as to the results that will be achieved. It is possible that multiple Procedures may be required and that even then success may not be achieved.

5. Consent to Photography For the purposes of accurate record keeping in connection with the care and treatment which I am receiving and will subsequently receive from the Clinic, I hereby consent to have the Clinic's staff take before, during, and after treatment close-up photographs of the involved area (s) and the anatomical region surrounding the involved area (s). These photographs shall be used for medical records only and shall be treated with the same confidentiality as the remainder of my record at the Clinic.

I have been given an opportunity to ask questions about my condition and treatment, the procedure to be used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent. By signing below, I certify that I have read and fully understand the contents of this document.

Patient Name (Print): ____

Patient Signature: X ______________________________ Date: __________