Laser Vein Treatment Consent

I hereby authorize and direct _______________ and whoever may be delegated to perform the following procedure: Remove or lighten the appearance of dilated superficial veins on my face or body. The procedure involves using a laser to coagulate the vessels and it is 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 risks/complications with laser treatments.

- Discomfort – some discomfort may be experienced during laser treatments.
- Healing – laser treatments can result in swelling, blistering, crusting, or flaking of the treated areas, which may require 1-3 weeks to heal. Once the surface has healed, it may be pink or sensitive to the sun for an additional 2-4 weeks, or longer in some patients.
- Bruising, Swelling, Infection – with some lasers, bruising of the treated area may occur. Additionally, there may be some swelling noted. Finally, skin infection is a possibility although rate, whenever a skin procedure is performed.
- Scarring – is a rare occurrence, but it is a possibility when the skin's surface is disrupted to minimize the changes of scarring, it is IMPORTANT that you follow all post treatment instructions carefully. Eye Exposure – protective eyewear (goggles), will be provided. It is important to keep these goggles on at all times during the treatment in order to protect your eyes from accidental laser exposure.

I understand my obligation to follow the instructions closely and visit the office as directed. I certify tha above consent and fully understand it. I have been given ample opportunity for discussion and all my que answered to my satisfaction.

Continued Treatment Consent

Date	Initials

Patient Signature:______________________________ Date:________________

Patient Name:______________________________

Witness Signature: ______________________________ Date:________________