SKIN REJUVENATION CONSENT

I, _____, consent to and authorize members of the Golla Center for Plastic Surgery staff to perform multiple treatments of Advanced Fluorescent Technology on me.

The nature and purpose of the treatment have been explained to me, and my questions have been answered to my satisfaction. I realize that darkening or lightening of the treated skin may occur, at times lasting many months following treatment. I also realize that other possible complications include superficial erosions, bruising, blistering, redness, swelling, and the rare possibility of permanent scarring.

I understand that topical anesthetics or ice may be used if I so choose. I understand that I must wear the protective goggles at all times during actual treatment.

I understand that the treated area requires ***specific cleansing and care, and sunscreen or sun block must be used 6 weeks post treatment***. I agree to follow post procedure instructions to minimize the risk of problems.

I understand that the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume those risks. I understand that I have the right to refuse the procedure. I am also aware that at least _____ treatments may be necessary to achieve best results.

I certify that I have read this entire consent and that I understand and agree to the information provided in this form. I certify that I am a competent adult at least 18 years of age. I understand that if I am a minor under the age of 18, the consent of my parent or legal guardian will be required before treatment. This consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns.

I authorize the taking of pictures before and after the procedure. Photographs help to document my progress. I consent to their use for any instructional, scientific, and educational or research purposes as deemed appropriate by Dr. Golla, MD or assistants. However, any such photographs will not identify me by name and my name will not be revealed to anyone without my specific consent.

I realize that no guarantee, warranty, or assurance has been made as to the treatment results. I agree to adhere to all safety precautions and regulations during the laser treatment.

Patient Name (Please Print) _____

Patient Signature _____ Date _____

Guardian Signature _____Date _____