PATIENT CONSENT FORM
FOR LASER GENESIS SKIN THERAPY

NAME:

I hereby authorize the staff at the re*be Skin Clinic to perform Laser Genesis Non-Ablative Skin Therapy on me. I understand that this procedure works on promoting vibrant and healthy looking skin. The Laser Genesis procedure is a revolutionary way to combat the signs of aging, without harsh chemicals or long recovery periods.

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, scarring and/or blistering.

I am aware of the following possible experiences/risks with Laser Genesis:
- DISCOMFORT – A slight warming sensation may be experienced during laser treatment.
- WOUND HEALING – Any laser procedure can result in swelling, blistering, crusting, or flaking of the treated areas, which may require one to three weeks to heal.
- 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 rare possibility whenever a skin procedure is performed.
- Pigment Changes (Skin Color) – There is a slight possibility that the treated area can become either hypopigmented (lighter), or hyper pigmented (darker), in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- Scarring – Scarring is a rare occurrence, but it is a possibility if the skin’s surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions carefully.
- Eye Exposure – Protective eyewear (shields) will be provided. It is important to keep these shields on at all times during the treatment in order to protect your eyes from accidental laser exposure.
- Treatments – The number of treatments may vary. The number of treatments needed to clear your pigmented lesion is unknown.

I authorize the taking of clinical photographs and their use for future treatments at this clinic. (you may refuse photographs and we will happily still treat you)

My photographs or cropped portions of them may be used for:
- showing treatment results to other clients at the re*be Skin Clinic
- scientific purposes in publications presentations and seminars
- presented to the internet as part of the re*be Clinics website
- presented to the public as information about the procedure or our clinic

ACKNOWLEDGMENT

I UNDERSTAND AND ACKNOWLEDGE THAT PAYMENTS FOR THE ABOVE PROCEDURE ARE NON-REFUNDABLE.

BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS PERMISSION FORM FOR LASER GENESIS TREATMENT AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.

Signature-Patient or Guardian ___________________________ Print Name/Relationship ___________________________ Date __________

Signature-Witness or ___________________________ Print Name/Relationship ___________________________ Date __________