Hetal Gor MD, FACOG

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Doctor you can Trust

CUTERA®

I hereby authorize Dr._____ or _____, under Dr. _____'s supervision to remove or lighten the appearance of vascular and/or pigmented lesions. The procedure involves using a laser or pulsed light device to coagulate the vessels or vascular lesions and/or treat pigmented lesions, age spots, and sun spots by melanin absorption. I understand it may take multiple treatments to obtain optimal results. Although these devices are effective in most cases, no guarantees can be made. I understand I may not experience complete clearance, and that it may take multiple treatments. Some conditions may not respond at all and, in rare cases, may become worse.

The procedure may result in the following adverse experiences or risks:

- DISCOMFORT – Some discomfort may be experienced during treatment.
- REDNESS/SWELLING/BRUISING –Short term redness (erythema) is common and swelling (edema) of the treated area may occur. Additionally, there may be some bruising.
- SKIN COLOR CHANGES – During the healing process, there is a slight possibility that the treated area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- WOUNDS – Treatment can result in burning, blistering or bleeding of the treated areas. If any of these occur, please call our office.
- BURNS and INFECTION - Infection is a rare possibility whenever the skin surface is disrupted, though proper wound care should prevent this. If signs of infection develop, such as pain, heat or surrounding redness, please call our office __(Phone number)_____.
- 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 provided by your healthcare staff.
- EYE EXPOSURE – Protective eyewear (shields) will be provided to you during the treatment. Failure to wear eye shields during the entire treatment may cause severe and permanent eye damage.

I acknowledge the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me
- Alternative treatments such as sclerotherapy or surgery
- Reasonably anticipated health consequences if the procedure is not performed
- Possible complications/risks involved with the proposed procedure and subsequent healing period

For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep Dr._____and staff informed should I become pregnant during the course of treatment.

Photographic documentation will be taken. I hereby do___do not___authorize the use of my photographs for teaching purposes.

ACKNOWLEDGMENT

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FOR TREATMENT OF VASCULAR/PIGMENTED LESIONS AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.

_____	_____	_____
Signature-Patient or Guardian	**Print Name/Relationship**	**Date**
_____	_____	_____
Signature-Witness	**Print Name**	**Date**