pelle
spa

Informed Consent for Laser Vein Treatment

Full Name _____Age _____ Date _____

The procedure to be performed is laser treatment of veins, telangiectasia, and cherry angioma. The purpose of this treatment is to attempt to remove, fade, or lighten the veins. This treatment is not a cure for vein disease, nor will it prevent further veins from developing. The results vary with each individual, and multiple treatments may be necessary. Some individuals may not be treatable due to skin type or certain medications. The laser produces energy that is absorbed by the targeted blood vessel and then is expelled through the body. Some veins may be too large to be safely treated with laser. Results may be immediate or they may take several months to fade or disappear. The following may or may not occur:

1. This treatment may feel like a moderate to severe pinprick or burst of heat that lasts only a few seconds. The area may be reddish-purple in color, hot, and slightly swollen.

2. There is a risk of blistering, scarring, hyperpigmentation (darkening of the skin), hypopigmentation (lightening of the skin) following treatment. Pigmentation changes usually resolve within 6 months, but permanent color change is possible. Avoiding sun exposure before and after treatment will reduce this risk.

3. Other rare complications include: Bleeding, infection, scarring, or allergic reaction.

4. I understand that sun exposure and not following post treatment instructions may increase my chances of complications. A broad spectrum sun protection with a minimum SPF 30 is to be used daily during the entire duration of treatments.

5. I will wear the protective eyewear provided at all times to prevent damage to my eyes. 6. I will notify the technician immediately if I experience any other complications not noted. Occasionally, unforeseen mechanical problems may occur with our machine and your appointment may need to be rescheduled. We will make every effort to notify you prior to your arrival. Please be understanding if we cause you any inconvenience.

☐ My questions have been fully answered and I have read or have had read to me this document, have not taken any medications which may impair my mental ability, do not feel rushed or under pressure and understand its contents. I hereby give my unrestricted informed consent for the procedure.

☐ I understand that cancellations must be made prior to appointments. I understand I must cancel 24 hours prior to my scheduled appointment or I will be charged $25.00 for every missed appointment.

☐ I give permission for photographs taken of all treated sites to be used for the medical record, and anonymously for teaching, illustration in scientific papers or for marketing and/or literature.

☐ I agree to follow up at recommended intervals to assess my status and to inform Pelle Spa, LLC of any problems that I may be having and allow examination at that time.

☐ I have been given and have read and understand the pre- and post-care instructions

☐ I am aware that it is my responsibility to inform Pelle Spa providers of my current medical conditions. I agree to abide by the above policy statements. I understand that, as with any cosmetic procedure, individual results may vary and that NO refunds will be given. I understand that if I am dissatisfied with the results of the services rendered that I am not entitled to a refund. I understand that as a valued customer of Pelle Spa, that I may contact them to determine if there is a remedy for my dissatisfaction. If I choose not to allow Pelle Spa to remedy the issue, or if i choose to allow Pelle Spa to remedy and I am still dissatisfied, that I am not entitled to a refund. I hereby release the technician performing the procedure, Pelle Laser Spa, LLC and Annette Randlemon, CNP from all liabilities associated with any and all of the above indicated procedures.

Signature

_____ Date _____

Signature of Parent/Guardian (if patient is under 18)

_____ Date _____

Provider Name and Signature

_____ Date _____

*This consent is good for one year.