

**SOUTHWEST WOMEN'S CARE**  
Hair & Vein Removal • Sun Spot Removal • Botox • Juvederm

**PERMISSION FOR LASER PEARL TREATMENT**

Do not sign this form until you have read it and fully understand its contents.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I acknowledge and understand that the following procedure has been described to me to my satisfaction:

**Ablative Resurfacing with the Pearl Laser System**

I hereby authorize Southwest Women's Care and its personnel to remove the very top layer of skin to improve the skin tone, texture, and brown spots. The procedure involves using a laser whose light is attracted to the water in your skin and heats it up. As a result, a portion of the outermost layer of your skin will slough (peel) off over a period of a few days. It may take multiple treatments to obtain optimal results, and it is possible that the results will be minimal or not help at all. The results may be temporary or permanent and there is no way to predict how long the results will last. Although these devices are effective in most cases, no guarantees can be made.

I am aware of the following possible experiences and/or risks:

1. **DISCOMFORT** – Some discomfort may be experienced during treatment. A topical anesthetic will be applied to your skin before treatment.
2. **REDNESS/SWELLING** – Redness (erythema) and/or swelling (edema) of the treated area is common and may occur. This usually resolves in a few days.
3. **PIGMENT CHANGES** – (Changes in skin color) – During the healing process, there is a possibility that the treated area can become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This usually temporary, but on rare occasion, it may be permanent. You should avoid sun exposure after the treatment and use sunblock.
4. **WOUNDS** – Treatment can result in burning, blistering, or bleeding of the treated areas. It is important that you not pick or scratch the sites as this may lead to permanent scars or promote an infection. If any of these occur, please call our office.
5. **INFECTION** – Infection is a possibility whenever the skin surface is disrupted, though proper wound care and keeping the treated area clean should prevent this. Herpes simplex (cold sores) is seen in a small percentage of patients, even if prophylaxis (anti-viral medication) is used. This may lead to scarring. If signs of infection develop, such as pain, heat or surrounding redness, please call our office.
6. **SCARRING** – Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the chances of scarring, it is **IMPORTANT** that you follow all post-treatment instructions carefully.

7. **EYE EXPOSURE** – Protective eyewear (shields) will be provided during the procedure. It is important to keep these shields on at all times during the treatment in order to protect your eyes from injury.
8. **ALLERGY** – There is a risk of an allergic reaction to the numbing cream.

The following points have been discussed with me:

1. Potential benefits of the proposed procedure.
2. Possible alternative procedures, such as chemical peels.
3. Probability of success.
4. Reasonably anticipated consequences if the procedure is not performed.
5. Most likely possible complications and/or risks involved with the proposed procedure and subsequent healing period.
6. Post-treatment instruction.

### **ACKNOWLEDGEMENT**

**I understand that laser treatment is not an exact science, and that no guarantee or assurances can be given to me concerning the results of this procedure.**

By signing this form, I acknowledge that I have read this form, that I fully understand its contents, and that I have been given ample opportunity to ask questions and that all questions have been answered to my satisfaction. I understand that I can call or return to the office at any time to ask for more information from the doctors or their staff.

I consent to allow the medical personnel at Southwest Women's Care under the supervision and control of its physicians to perform Laser Pearl treatments.

For women of childbearing age: By signing below I indicate that I am not pregnant. Furthermore, I agree to keep the physicians of Southwest Women's Care and its staff informed should I become pregnant during the course of treatment.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Patient - Print Name

\_\_\_\_\_  
Witness - Print Name