DERMATOLOGY
OF EASTERN IDAHO
MEDICAL SPA

703 Rigby Lake Dr, Rigby, Idaho | Phone (208) 745-0200

INFORMED CONSENT AND RELEASE FORM CORTEX™ FRACTIONAL CO_2 LASER TREATMENT

As a patient, it is important for you to understand the expected results and risks of fractional CO_2 skin resurfacing with the Cortex™ CO_2 Laser System. Please read this document carefully. Before signing this document, please ask your physician about any aspect of this document, or the laser procedure, that you do not understand.

The use of the Cortex™ CO_2 Laser System is contraindicated if a patient does not tolerate any procedure or effect that is necessarily associated with the use of a medical laser.

The Cortex™ CO_2 Laser System is intended to be used for the ablation and coagulation of soft tissue in the performance of skin resurfacing and in the treatment of rhytids, wrinkles, furrows and acne scars.

_____ I understand that the results of a fractional CO_2 laser treatment may vary depending on the condition of skin, skin type, and area treated.

_____ I understand that there is no guarantee of results and that more than one treatment may be needed in order to get the results I desire.

_____ I do NOT have any of the following conditions that could make a CO_2 laser treatment contraindicated:

- Pregnancy (or currently breast feeding)
- Herpes Simplex (cold sores / fever blisters) in the area to be treated
- History of keloid scarring
- Use of oral retinoids (e.g. Accutane® or other isotretinoin) within the last 6 months
- Use of medications that increase photosensitivity (the sensitivity of my skin to light)
- Recent sun exposure or use of a tanning bed within the last month
- Family history of vitiligo (milky white patches/spots on skin)
- Tattoo in treated area
- Auto-immune disorders
- Diabetes
- Recent use of aspirin, ibuprofen (e.g. Motrin® or Advil®), or other anti-inflammatory medications
- Previous allergic reaction to a skin treatment or to topical medication used during that treatment

_____ I understand that I must have special laser protective eyeshields covering my eyes during treatment.

_____ I understand that this is a cosmetic procedure (not covered by insurance) and that there are other alternative treatments for skin rejuvenation besides a fractional CO_2 laser treatment.

_____ I am fully aware of the post-operative side effects and possible complications from a fractional CO_2 laser treatment, which include, but are not limited to:

- Mild to moderate discomfort
- Redness or swelling at the treated area
- Sun and/or skin sensitivity
- Blistering
- Bleeding, bruising or infection
- Temporary or permanent skin pigmentation changes: hypo- or hyperpigmentation
- Scarring
- Eye Exposure (protective eyewear will be provided to me)

_____I understand that photos may be taken for my medical records

_____I certify that I am a competent adult of at least 18 years of age and that this consent is given freely and voluntarily.

_____I hereby indemnify and hold harmless Ellman International, the treating technician, and Dermatology of Eastern Idaho from any and all liability, damages, cost and expenses arising from or out of the use of the Cortex Fractional CO_2 laser for the treatment of wrinkles, furrows, and scarring.

My signature below signifies that the physician or consultant has answered all of my questions. I understand the risks, complications, expected results, and expense of the treatments. I have read and understand this document and request that the doctor or other qualified staff perform this procedure on me.

Patient Name_____

Signature_____ Date_____

Physician Name_____

Signature_____ Date_____