



INFORMED CONSENT FOR PICOSURE TATTOO REMOVAL / OR LASER SKIN REVITALIZATION

Patient Name: _____ DOB: _____

The PicoSure laser produces an intense burst of light that is absorbed by the pigmented lesion or tattoo ink. All personnel in the treatment room, including me, will wear protective eyewear to prevent eye damage from the intense light.

The sensation of the laser light on skin is uncomfortable and may feel like a slight pinprick or the sensation of heat. These sensations may last for a few hours.

Tattoos may blister and have pinpoint bleeding for a few days after treatment. Following a facial treatment, the treated area may be red, slightly swollen, or rarely may develop an acne-like breakout.

The area should be treated delicately following treatment. Multiple treatments may be necessary.

- I have been informed that hyperpigmentation (darkening of the skin), and hypopigmentation (lightening of the skin) are possible complications of the procedure. I understand that sun exposure, as well as not adhering to the posttreatment instructions provided to me may increase my chance of complications.
- Avoid sun exposure before and after treatment. Use a 30+ sunblock to protect exposed treated areas during day at all time.
- I understand that sun exposure, as well as not adhering to the post treatment instructions provided to me may increase my chance of complications.

My signature below constitutes my acknowledgement that I am a competent, consenting adult of at least 18 years of age (or my parent or legal guardian is giving consent on my behalf.) I certify that I have read or have had read to me, the content of this informed consent form. I understand the risks and alternatives involved in this procedure. I have had the opportunity to ask any questions that I had, and all of my questions have been answered. I have agreed to provide aftercare as directed for this treatment by this facility.

Patient Signature: _____ Date: _____
(Or Legal Guardian)