Cynosure 1540 Fractional Laser Consent Form
For: Skin Tightening, Stretch Marks, and Scar Reduction

1. **Pre Care:** For one week prior to treatment, avoid sun exposure, tanning beds, and tanning creams. If you have sun exposure within the past week, you will not be treated. If you have a history of herpes, medications to reduce the risk of an outbreak should be prescribed for one week._____ (initial)
2. **Eye Exposure:** It is important that you keep protective goggles on at all times during treatment to protect your eyes. _____ (initial)
3. **Discomfort:** Some discomfort may be experienced during laser treatment. _____(initial)
4. **Healing:** Laser treatment can result in swelling, redness, crusting or flaking of the treated areas. This may require one to three weeks to heal. Once the surface has healed, it may be pink or sensitive to the sun for an additional two to four weeks or longer in some patients. _____(initial)
5. **Pigment Changes:** During the healing process, there is slight possibility that the treated area can become either lighter or darker in color compared to the surrounding skin. This is usually temporary, but on a rare occasion, it may be permanent. _____(initial)
6. **Guarantee:** Due to the nature of this treatment an exact result cannot be predicted and I acknowledge that no guarantees have been made to me as to the results that may be obtained. The course of treatments may require a number of treatments, occurring at four to six week intervals. The actual treatment time and number of treatments needed will be dependent on condition being treated. I understand that payments for laser treatments are non-refundable. _____(initial)
7. **Post Care:** Following the procedure, clean the treated area with gentle cleanser and apply SPF 45 or greater. I understand that it is my responsibility to follow the pre and post treatment instructions given to me and to contact the office if any complications occur. _____(initial)
8. **Photographs:** I give permission for my photographs to be used to help document my treatment course. Complete confidentiality will be maintained. _____(initial)

I certify that I have read and understand all information presented to me before signing this consent form. I have also been given the opportunity to ask questions.

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release Subroto Bhattacharya, MD, Hayley Mateen, NP, Jennifer Richardson, NP and Danvers Family Doctors, P.C. from all liabilities associated with the above indicated procedure.

Patient or legal guardian_____ Date:_____

Printed Name:_____

Witness (Laser Technician)_____ Date:_____