Hayes Clinic
520 N. Collegiate Dr. Paris, Tx 75460 903-784-1608

INFORMED CONSENT FOR ACNE TREATMENT

This consent form includes a general description of a dermatological treatment, including possible benefits and risks that may occur as a result of these treatments. Your doctor or nurse will describe and discuss the specific details of your procedure with you and answer your questions.

Please read the applicable sections of this consent form carefully. This form may contain words that are unfamiliar to you. Please ask your doctor or one of his staff to explain any words or information that you do not clearly understand. You may take home an unsigned copy of this consent form to think about or discuss with family or friends before making your decision.

PROCEDURES

Non-ablative (no removal of body tissue) laser treatment is a technique for treating acne lesions on the face, chest, neck and back. Non-ablative lasers are designed to penetrate into the lower layers of the skin without injuring the outer layers.

A topical anesthetic may be applied prior to treatment to reduce discomfort during the procedure. Photographs of the treatment area are recommended and may be taken for your medical chart and future comparison. Multiple treatments may be necessary to achieve complete satisfaction. Short-term redness and/or swelling can be expected.

Benefits of this treatment include the possible reduction of acne lesions and a reduction in the severity of lesions.

Possible risks or discomforts (side effects) may include pain, burning, blister formation, stinging sensation, infection, pigmentary changes including decrease or increase in skin color at the site of treatment, scar formation, laser/Intense Pulsed Light induced "cold-sore-like" blistering, skin eruptions at the site of treatment and poor cosmetic outcome. **Initial:____ Date:____**

GENERAL RISKS

Eye injury due to use of the laser or Intense Pulsed Light system is a risk to the patient and to the clinician, however, the risks are dramatically reduced *(almost completely eliminated)* with the correct use of proper eyewear. **Initial:____ Date:____**

Please read and initial the following:

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), and further, that:

_____ I have read and understand the information provided in this form.
_____ I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction.
_____ I have received all of the information I desire concerning my procedure.
_____ I give permission for before and/or photographs to be taken of the areas treated and said photographs to be used for promotional and/or educational purposes by Gaylen G. Hayes, D.O.
_____ I fully understand all post treatment reccomendations and agree to adhere to them.
_____ I freely assume any risks of complications or injury from known or unknown causes associated with, relating to, or otherwise arising out of this procedure.
_____ I have the right to or refuse any procedure at any time prior to its performance.
_____ I must notify Gaylen G. Hayes, D.O. and/or clinicians if my medical history changes prior to subsequent treatments.

Patient Name *(Please Print)*	**Date**	**Patient Signature**	**Date**
Gaylen G. Hayes, D.O	**Date**	**Witness**	**Date**