NORTHSHORE DERMATOLOGY
the complete skincare & laser center

I,_____understand that:

1. _____My condition is known as _____.
2. _____FotoFacial/RF is not an experimental treatment.
3. _____FotoFacial/RF is a series of at least 5 treatments at 3-4 weeks intervals.
4. _____However, sometimes more than 5 treatments are needed, which there is an additional charge for these treatments. The wavelength, exposure, duration, and energy level are chosen to selectively damage targeted blood vessels with minimum damage to the surrounding tissue. The intense pulsed light energy is absorbed by the blood vessel. The vessel walls are damaged, absorbed by the body, and the lesions are rendered invisible.
5. _____FotoFacial/RF intends to treat benign vascular and non-vascular skin conditions to lighten, fade, improve or remove the unwanted blood vessels, freckles, birthmarks, fine lines, uneven skin coloring, tone or texture.
6. _____Contraindictions to FotoFacial/RF treatment include: pregnancy, use of medications that increase photosensitivity, use of anticoagulants, diabetes, history of keloid scarring, history of bleeding disorders, recent extensive sun exposure, planned extensive sun exposure.
7. _____If I am taking Accutane, I must discontinue the medication for 3 months prior to beginning the series of FotoFacial/RF.
8. _____There is a possibility of side effects such as scarring, permanent discoloration temporary or permanent, partial or complete hair loss (moustache/beard) short term effects such as reddening, mild burning, bruising, blistering, or swelling of the skin.
10. _____There may be other treatment options for my condition. These have been explained to me and are also available upon request.
11. _____FotoFacial/RF is generally considered to be a cosmetic procedure and not covered by insurance. Thus, I am responsible for all treatments costs.
12. _____For FotoFacial/RF to be optimally successful, I accept responsibility in complying with the skin care instructions provided and discussed.
13. _____Photographs will be taken to monitor FotoFacial/RF results and may or may not be used for publication and or teaching purposes. Should they be used in public, all measures will be taken to guard my identity and maintain confidentiality.

_____I get fever blisters.

_____I have never had a fever blister.

I consent to this procedure and fully under stand the risks that have been explained to me.

_____ _____
Signature of Patient/Patient's Agent Date

_____ _____
Signature of Witness Signature of Physician