Date: _____

COLUMBIA SKIN CLINIC

# Intense Pulsed Light (IPL) History and Consent

**Patient's Past History** (check all that apply)

□ Epilepsy or Seizure Disorder
□ Compromised Immune System
□ Cold Sores or Fever Blisters
□ Lupus
□ Sun Sensitivity

**Do you use or take by mouth any of the following?**

□ Accutane (now or in the past)
□ Blood Thinners, Aspirin, or Ibuprofen
□ Photosensitizing Vitamins or Supplements, i.e. St. John's Wort, Ginkgo Biloba, Vitamin A or E

| | | |
|---|---|---|
| **Are you currently being treated for any active infections?** | YES | NO |
| **Are you currently pregnant?** | YES | NO |

**Consent**

I authorize Columbia Skin Clinic to perform laser/pulsed light cosmetic dermatology treatments on me including but not limited to deep tissue heating, soft tissue coagulation, hair removal, treatment of pigmented lesions, and/or vascular lesions. I understand that the procedure is purely elective, that the results may vary with each individual, and multiple treatments may be necessary.
I understand the following:

- Serious complications are rare but possible.
- Common side effects include temporary redness and mild "sunburn" like effects that may last a few hours to 3-4 days or longer.
- Pigment changes, including hypopigmentation (lightening of the skin) or hyperpigmentation (darkening of the skin) lasting 1 – 6 months or longer may occur.
- Freckles may temporarily or permanently disappear in treated areas.
- Other potential risks include crusting, itching, pain, bruising, burns, infection, scabbing, scarring, swelling, and failure to achieve the desired result.
- Lasers/intense pulsed light can cause eye injury and protective eyewear must be worn during treatment.
- Sun or tanning lamp exposure and not adhering to the post-care instructions provided to me may increase my change of complications.

I consent to photographs being taken to evaluate treatment effectiveness, for medical education, training, professional publications, or sales purposes. No photographs revealing my identity will be used without my written consent. If my identity is not revealed, these photographs may be used and displayed publicly without my permission.

Before and after treatment instructions have been discussed with me. The procedure as well as potential benefits and risks have been explained to my satisfaction. I have had all my questions answered. I freely consent to the proposed treatment.

Patient Name: _____ DOB: _____

Patient Signature: _____ Date: _____