CONSENT FOR LASER/LIGHT-BASED TREATMENT

I authorize David Lenser, MD or Terri Lenser, RN to perform laser/pulsed light cosmetic skin treatments on me, including, but not limited to, the treatment of pigmented lesions (for example, sun spots, age spots, and other skin discolorations), vascular lesions (for example, red spots and small spider veins, but not varicose veins), wrinkles (rhytides), furrows, fine lines, textural irregularities, nonablative skin resurfacing, soft tissue coagulation, and reducing or eliminating hair. I understand that the procedure is purely elective, that the results may vary with each individual, and multiple treatments may be necessary.

I understand that:

- The Palomar Icon TM Aesthetic System is a pulsed-light and laser system that delivers a precise pulse of light energy that is absorbed by a chromophore in skin, for example, hemoglobin in the blood or pigment in a lesion, causing a thermal reaction. All personnel in the treatment room, including me, must wear protective eyewear to prevent eye damage from this light energy.

- The sensation of light is sometimes uncomfortable and may feel like a moderate to severe pinprick or flash of heat. Topical anesthetic may be advisable for laser skin resurfacing treatments. If the practitioner or physician elects to use an anesthetic to reduce discomfort during any light-based treatment, all options and risks associated with the anesthetic will be discussed with me.

- The treated area may be red and swollen for 2-24 hours or longer. Cooling the area after the treatment (for example, ice packs, topical gels) may help reduce discomfort and swelling.

- Common side effects include temporary redness (erythema) or mild "sunburn"-like effect that may last a few hours to 3-4 days or longer. Other potential side effects include, but are not limited to, crusting, irritation, itching, pain, burns, scabbing, swelling (edema), broken capillaries, bronzing, and acne or herpetic breakouts. There also is a risk of resulting unsatisfactory appearance and failure to achieve the desired result.

- Pigment changes, including hypopigmentation (lightening of the skin) or hyperpigmentation (darkening of the skin), lasting 1-6 months or longer or permanently may occur. Freckles may temporarily or permanently disappear in treated areas.

- Serious complications are rare but possible, such as scarring, blood clots, skin loss, hematomas (collection of blood under the skin), and allergic reaction to medications or materials used during the procedure.

- I understand and accept that with skin resurfacing treatments there may be an increased length of social downtime associated with the level of treatment. There also is a chance of additional side effects like blanching and significant redness. There is no guarantee that the expected or anticipated results will be achieved.
• Sun, tanning bed, or tanning lamp exposure, the use of self-tanning creams, and not adhering to the post-treatment instructions provided to me may increase my chance of complications. I must avoid the sun, tanning beds, and sunless tanning lotions and use sunblock (SPF 45 recommended) after treatment.

• There is a possibility of coincidental hair removal when treating pigmented or vascular lesions in hair-bearing areas. There is a risk that the hair regrowth may be changed, such as little or no regrowth or more regrowth than before.

• I should call my provider as soon as possible if I have any concerns about side effects or complications after treatment.

• Not providing my medical history before proceeding with a light-based treatment could impact treatment results and cause complications.

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

Before and after-treatment instructions have been discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction.

I have read and understand all information presented to me before consenting to treatment. I have had all my questions answered. I freely consent to the proposed treatment today as well as for future treatments as needed.

Signature ______________________________________    Date _______________________

Print Name _____________________________________

Provider Signature _______________________________    Date _______________________

Print Name _____________________________________
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your eye color?</td>
<td>Light Blue or Gray, Blue or Green, Hazel, Light Brown, Dark Brown, Brownish Black</td>
</tr>
<tr>
<td>What is the natural color of your hair?</td>
<td>Red, Sandy Red, Blonde, Dark Blonde, Chestnut, Brown, Black</td>
</tr>
<tr>
<td>What is the color of your skin (unexposed areas)?</td>
<td>Reddish, Very Pale, Pale with beige tint, Light Brown, Dark Brown</td>
</tr>
<tr>
<td>Do you have freckles on sun-exposed areas?</td>
<td>Many, Several, Few, Incidental, None</td>
</tr>
<tr>
<td>What happens when you stay in the sun too long?</td>
<td>Painful Redness, Blistering, Peeling, Blistering, followed by Peeling, Burns, sometimes followed by Peeling, Rarely Burns, Never had Burns</td>
</tr>
<tr>
<td>To what degree do you turn brown?</td>
<td>Hardly any or not at all, Light Tan, Reasonable Tan, Tan Very Easily, Turn Dark Brown Quickly</td>
</tr>
<tr>
<td>Do you turn brown several hours after sun exposure?</td>
<td>Never, Seldom, Sometimes, Often, Always</td>
</tr>
<tr>
<td>How does your face respond to the sun?</td>
<td>Very Sensitive, Sensitive, Normal, Very Resistant, Never had a Problem</td>
</tr>
<tr>
<td>When did you last expose yourself to the sun, tanning bed or self-tanning creams?</td>
<td>More than 3 months ago, 2-3 Months ago, 1-2 Months ago, Less than 1 Month ago, Less than 2 Weeks ago</td>
</tr>
<tr>
<td>How often is the area you want to have treated exposed to the sun?</td>
<td>Never, Hardly Ever, Sometimes, Often, Always</td>
</tr>
</tbody>
</table>

Add above for TOTAL SCORE: 

<table>
<thead>
<tr>
<th>Score</th>
<th>Fitzpatrick Skin Type:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>I</td>
</tr>
<tr>
<td>1</td>
<td>II</td>
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<tr>
<td>2</td>
<td>III</td>
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<tr>
<td>3</td>
<td>IV</td>
</tr>
<tr>
<td>4</td>
<td>V - VI</td>
</tr>
</tbody>
</table>

Client Name: _________________________________ Date: ______________ Score: ________
MEDICAL HISTORY FORM

Last Name: __________________________ First Name: __________________________

Address: __________________________________________________________________________________

City: __________________________ State: ___________ Zip Code: ___________

Email Address: __________________________________________________________________________________

Telephone: Home: ____________ Work: ____________ Cell: ____________

Date of Birth: __________________________ Sex: Female _____________ Male: _____________

Family Doctor: __________________________ Phone: __________________________

Pharmacy: __________________________ Phone: __________________________

Emergency Contact: __________________________ Phone: __________________________

Which body area/areas or condition would you like treated? _____________________________________

________________________________________________________________________________

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS:

1. Do you have ANY current or chronic medical illnesses?
   Disclose any history of heat urticaria (hives) diabetes, autoimmune disorders or any immunosuppression, blood disorders, cancer, bacterial or viral infections, medical conditions that significantly compromise the healing response, skin photosensitivity disorders, neuro-muscular disease, diabetes, cold sores/fever blisters, mental disease, or ANY other condition or illness.
   Please list: __________________________________________________________________

2. Do you have ANY current or chronic skin conditions?
   Also disclose any history of vitiligo, eczema, melasma, psoriasis, allergic dermatitis, any diseases affecting collagen including Ehlers-Danlos syndrome, scleroderma, skin cancer, or ANY other skin condition.
   Please list: __________________________________________________________________

3. Have you ever had any surgeries?
   Please list: __________________________________________________________________

4. Are you currently under a doctor’s care? If so, for what reason?
   _____________________________________
5. Do you take/use ANY medications (prescription & nonprescription), vitamins, herbal or natural supplements, on a regular or daily basis?  
   Please list: ____________________________________________________________

6. Are there any topical products (both medical and non-medical) that you use on your skin on a regular or daily basis?  
   Please list: ____________________________________________________________

7. Do you take/use ANY systemic/oral steroids (e.g.: prednisone, dexamethasone)?  
   Please list: ____________________________________________________________

8. Do you have ANY allergies to medications, foods, latex or other substances?  
   Please list: ____________________________________________________________

9. Do you smoke?  

10. Do you drink? If yes, how many drinks per week?  

11. Do you exercise? If so, please circle one: rarely frequently daily  

12. (For women) Are you or could you be pregnant?  

13. (For women) Are menstrual periods regular, or have you ever been diagnosed with Polycystic Ovarian Disorder?  

14. Do you have a history of herpes I or II in the area to be treated?  

15. Do you have a history of keloid scarring or hypertrophic scar formation?  

16. Do you have a history of light induced seizures?  

17. Do you have any open sores or lesions?  

18. Do you have any history of radiation therapy in the area to be treated?  

19. In the last six (6) months, have you used any of the following: anticoagulants or blood-thinning medications; photosensitizing medications; or anti-inflammatory or blood-thinning medications?  
   Please list product name and date last used: __________________________________

20. In the last three (3) months, have you used any of the following products: glycolic acid or other alphahydroxy or betahydroxyacid acid products: exfoliating or resurfacing products or treatments?  
   Please list product name and date last used: __________________________________

21. Do you have or have you ever had any permanent make-up, tattoos, implants or fillers, including, but not limited to, collagen, autologous fat, Restylane®, etc.?  
   If yes, please list locations on or in the body and dates: ________________________

22. Do you have or have you ever had any Botulinums, such as Botox® or Dysport®?  
   If yes, please list locations on or in the body and dates: ________________________

23. Have you taken Accutane® (or products containing isotretinoin) in the last 12 months?  

24. Have you taken Tretinoin (like Retin-A®, Renova®) in the last 6 months?  

25. Have you had any unprotected sun exposure, used tanning creams (including sunless tanning lotions) or tanning beds or lamps in the last 4-6 weeks?  

THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature: ____________________________    Date: ______________________