

COOL BREEZE LASER
INFORMED CONSENT

Patient name: _____ **Chart#** _____

You have the right to be informed about your treatment options so that you may make the decision whether or not to undergo the Cool Breeze Laser procedure. This disclosure is not meant to scare or alarm you; it is simply an effort to make you more educated so that you may give an informed consent for treatment.

While Cool Breeze is effective in most cases, no guarantee can be made that a specific patient will benefit from the procedure. Additionally, the nature of the laser procedure may require a patient to return for other visits in order to achieve the desired results. I understand that this procedure is cosmetic and will not be covered by insurance.

I acknowledge that, while the goal of such a procedure is to build collagen, the realistic results average between 20-25% improvement. No specific guarantees can or have been made concerning the expected results. Some patients notice improvement, while others have minimal or no improvement. I understand the goal is improvement, not perfection.

This procedure has been fully explained to me and I authorize the treatment of Cool Breeze laser to treat wrinkles/acne scarring. The following points have been discussed with me:

- The possible benefits of the procedure.
- The possible alternative procedures or no treatment at all.
- The probability of success.
- The possible complications/risks such as discomfort, bruising/swelling, pigmentation changes, and scarring.

I certify that I have read the above consent form and I fully understand. I have been given ample opportunity for discussion and all my questions have been answered to my satisfaction. I have received no medication before signing this consent.

Patient Signature

Date

Witness