

DERMATOLOGY CONSULTANTS OF SOUTH FLORIDA, P.A.
CONSENT FOR TATTOO AND PIGMENTED LASER TREATMENTS

Patient Name: _____ Chart# _____

I hereby consent to have the practitioner perform laser surgery on me. I understand that:

- 1) Multiple treatments may be involved. **Initial**_____
- 2) The laser may have no affect whatsoever on my condition.
Initial_____
- 3) The laser may result in some loss of pigment in the area treated.
Initial_____
- 4) The laser treatment may result in increased pigmentation in the area. **Initial**_____
- 5) There will possibly be purple marks in the areas treated. These marks will last approximately 1-2 weeks. I understand that these areas need to be treated carefully and not picked at or removed until they fall off. **Initial**_____
- 6) I understand that I must remain out of the sun during the healing process. I will obtain the best results if I avoid the sun at least one month after treatment. **Initial**_____
- 7) I understand that there will be some pain involved in the procedure. **Initial**_____
- 8) I understand that I must avoid the use of blood thinners, such as aspirin, for the next week with approval from my doctor.
Initial_____
- 9) I understand that there is risk of possible scarring, infection, or other unforeseen complications. **Initial**_____

Patient Signature

Date