NLite Laser Treatment

The NLite Laser is FDA-approved for the purpose of reducing the appearance of wrinkles by using a specific frequency of yellow laser. This procedure is nonablative, which means that it does not cut or burn the outermost layer of skin.

Patient’s Initials

____ The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.

____ Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.

____ I understand and accept that the most likely material risks and complications of NLite laser treatment have been discussed with me and may include but are not limited to:

  • allergic reaction
  • edema
  • redness

____ I understand that a pre-test will be performed, and my skin evaluation and assessment will determine eligibility for this treatment.

____ I am aware that smoking during the pre- and postoperative periods could increase chances of complications and agree to quit four weeks prior to and after this treatment.

____ I have informed the doctor of all my known allergies.

____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.

____ I have been advised whether I should avoid taking any or all of these medications on the days surrounding the procedure.

____ I understand that a second treatment may be necessary.

____ I understand that this treatment is a cosmetic procedure and that I will be responsible for any and all costs of this treatment and any follow-up treatments.

____ I understand the reasons for laser safety eye wear, and I will comply with instructions.

____ I am aware and accept that no guarantees about the results of the procedure have been made.

____ I have been advised of the probable consequences of declining recommended or alternative therapies.

____ I have been informed of what to expect postoperatively, including but not limited to: estimated recovery time, anticipated activity level, and the possibility of additional procedures.

____ The doctor has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct ______________________, M.D., with associates or assistants of his or her choice, to perform the following procedure of NLite Laser treatment on, ______________________ at ______________________.

(name of facility) (patient name)

Continued
I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

_______________________________                  _______________________________
Patient or Legal Representative Signature/Date/Time                                                   Relationship to Patient

_______________________________                      _______________________________
Print Patient or Legal Representative Name                                                                           Witness Signature/Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or the patient’s legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

_____________________________
Physician Signature/Date/Time

_______ copy given to patient                                                  _______ original placed in chart
initial                                                                                         initial