

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

initial copy given to patient

initial original placed in chart

SAMPLE