LOTUS SPA EAU CLAIRE
4956 Bullis Farm Road
Eau Claire, WI 54701

Informed Consent

BBL™ BroadBand Light

I, _____,
authorize _____, and / or a designated practitioner of _____ to perform BBL on the following area(s) of my body:
_____

I understand the nature, goals, limitations and possible complications of this procedure and have discussed alternative forms of treatment. I have had the opportunity to ask questions about the procedure, its limitations and possible complications.

I clearly understand and accept the following:

1. The goal of laser surgery or BBL treatments, as in any cosmetic procedure is improvement, not perfection. My result might not be perfect, and the number of treatments necessary is dependent on several factors including skin color and sun exposure.
2. Contraindications may include pregnancy, use of medication that increases photo sensitivity, diabetes, history of keloid scarring, use of anticoagulants, and bleeding disorders. If you have a history of seizures or taking medication to prevent seizures, you should not have light based treatments as flashing lights may trigger a seizure.
3. There may be more treatments necessary than I anticipated.
4. Additional costs may occur should complications develop from the procedure(s): secondary procedures, treatments, referrals, hospitalization charges or other fees are my (the patient) responsibility.
5. There is no guarantee that the expected or anticipated results will be achieved.
6. There is a risk of harmful eye exposure to the laser energy. Safeguards have been provided including the use of safety eyewear during treatment. It is important for you to keep this protective eyewear on at all times during treatment to protect your eyes from accidental exposure.
7. Over time, with new sun exposure, additional treatments may be needed to maintain the desired results. Adequate sun protection (i.e. good sunscreen, etc.) will reduce the need for future treatments.

Although complications are infrequent following these treatments, I understand the following side effects or complications may occur or are theoretically possible and could happen to me. These include but are not limited to:

1. Discomfort at the treatment site with redness and possibly some edema (swelling).
2. Decrease or increase in pigmentation that may last 1-3 months or more and, in some cases, could be permanent.
3. Activation of cold sores.
4. Infection
5. Blisters and/or crusting
6. Bruising
7. Redness following the treatment that may last 2 days or more.

8. There is a rare chance of scarring, including hypertrophic scars or keloids, which are abnormal, heavy raised scars. To minimize the chances of scarring it is important that you follow all postoperative instructions carefully. I understand the potential risks, had the opportunity to ask questions, and consent to treatment with the laser.

☐ I understand that the treatment by the Sciton BBL system involves payment, and the fee structure has been fully explained to me. These services are typically not covered by insurance, thus placing full responsibility on me for payment. There will be a fee for subsequent procedures.

☐ I also understand that there are other options for treatment that are available and each of these other options has been fully explained to me.

Photography

I do ____ consent to photographs and other audio-visual and graphic materials before, during, and after the course of my therapy to be used for medical, marketing, and education purposes. Although the photographs or accompanying material will not contain my name or any other identifying information, I am aware that I may or may not be identified by the photos.

I have read and understand all information presented to me before signing this consent form. I have been given an opportunity to have all of my questions answered to my satisfaction. I understand the procedure and accept the risks. I agree to the terms of this agreement.

Patient's Name (Printed): _____

Signature: _____ Date: _____

Witness Signature :_____ Date: _____