



CONSENT FOR TITAN LASER TREATMENT

Do not sign this form until you have read it and fully understand its contents.

Patient Name: _____

I acknowledge and understand that the following procedure has been described to me to my satisfaction:

Laser Rejuvenation using the Titan Laser

I hereby authorize and direct Kristen M. Jacobs to treat me with the Titan device. I understand that this procedure works by creating a thermal response in the dermis that induces tightening of skin laxity and collagen enhancement without damage to the outer layer of skin. There is little or no downtime associated with this treatment. It is possible the result will be minimal or not help at all.

The following points have been discussed with me:

1. The potential benefits of the proposed procedure.
2. The possible alternative procedures.
3. The probability of success.
4. The most likely possible complications/risks involved with the proposed procedure and subsequent healing period; including, but not limited to, blistering, infection and/or scarring.
5. Photographs will be taken and may be used for educational purposes.
6. Post treatment instructions.

I am aware of the following possible experiences/risks with the Titan Treatment:

1. DISCOMFORT – Some discomfort may be experienced during treatment.
2. WOUNDS – Treatment can result in burning, swelling, bruising, blistering, or bleeding of the treated areas, which may require one to three weeks to heal. As with any injury to the skin, there is a potential for poor wound healing.
3. INFECTION – Infection is a rare possibility whenever a skin procedure is performed, though proper wound care should prevent this. If blistering or signs of infection develop, such as pain, heat or surrounding redness, please call our office at 618-288-9117.
4. BRUISING/SWELLING – Bruising (purpura) of the treated area may occur. Additionally, there may be some swelling (edema) noted.
5. PIGMENT CHANGES (Skin Color) – During the healing process there is a slight possibility that the treated area can become either lighter, or darker, in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.

Initial _____

6. SCARRING – Scarring is a rare occurrence, but it is a possibility if the skin’s surface is disrupted. To minimize the chances of scarring, it is IMPORTANT not to pick, rub or scratch the sites as this may lead to permanent scars.

7. EYE EXPOSURE - Protective eyewear (shields) will be provided during the procedure. It is important to keep these shields on at all times during the treatment in order to protect your eyes from injury.

I understand that the medical personnel and other assistants will rely on statements made by me to determine that the procedure is safe and effective.

ACKNOWLEDGMENT

I understand that laser rejuvenation using the Titan laser is not an exact science, and that no guarantee or assurances can be given to me concerning the results of this procedure.

I understand and acknowledge that payments for the above procedure are non-refundable. By signing this form, I acknowledge that I have read this form, that I fully understand its contents, that the disclosures referred to herein were made to me, and that I have been given ample opportunity to ask questions and that all questions have been answered to my satisfaction. I understand that I can call or return to the office at any time to ask for more information from the doctor or her staff.

I authorize the taking of photographs before, during and after the laser procedures. I understand that these photographs may be used for medical education, research and documentation of the medical record.

I consent to allow the medical personnel at Kristen M. Jacobs M.D., P.C. under the supervision and control of Kristen M. Jacobs. to perform Laser Rejuvenation using the Titan Laser.

I have read and understand **PRE and POST care** for my Laser Treatment.

Patient Signature

Date

Physician Signature