Soliz Healthcare Solutions

Phone# 602-325-5880

General Laser Patient Consent Form

I hereby authorize Soliz Healthcare Solutions to perform a laser treatment using wavelengths appropriate for my condition. The treatment may involve wavelengths such as **532nm, 755nm, 1064nm, and others**, depending on the indication. These wavelengths may be used for hair removal, vascular lesion reduction, pigmented lesion removal, skin resurfacing, and other aesthetic treatments. I acknowledge that multiple treatments may be required to achieve desired results, and outcomes are not guaranteed. Factors such as genetics, hormones, and medications may impact results, and in some cases, no improvement may be seen.

**Possible Treatment Sites:** The procedure may be performed on various areas of the body, including but not limited to the face, neck, chest, arms, legs, back, underarms, bikini area, and other areas requiring treatment.

**Possible Risks and Adverse Effects:** I understand that the procedure may result in the following effects:

* **Discomfort/Pain:** Some mild discomfort or pain may be experienced during treatment.
* **Redness/Swelling/Bruising:** Temporary redness (erythema) or swelling (edema) of the treated area is common. Bruising may also occur.
* **Hypopigmentation/Hyperpigmentation:** Temporary lightening or darkening of the treated skin may occur. Rarely, these changes can be permanent.
* **Wounds:** There is a small possibility of burns, blistering, or pinpoint bleeding.
* **Infection:** Although uncommon, infection is possible if proper aftercare is not followed. Signs include pain, heat, or redness surrounding the area.
* **Scarring:** Rare, but a possibility if the skin is disrupted. Adhering to aftercare instructions reduces this risk.
* **Eye Exposure:** Protective eyewear will be provided and must be worn throughout the treatment to prevent potential eye damage.
* **Herpes Simplex Reactivation:** For individuals with a history of cold sores, laser treatments around the mouth may trigger a recurrence.
* **Sun Sensitivity:** Sun exposure before and after treatment may increase the risk of adverse effects. Avoiding direct sunlight and using sun protection is strongly recommended.
* **Systemic Reactions:** Certain medications or conditions may influence how the skin reacts to treatment

**Acknowledgment:** I acknowledge the following points have been discussed with me:

* Potential benefits of the proposed procedure.
* Alternative treatment options.
* Possible complications and risks involved.
* The necessity of multiple treatments for best results.
* The importance of adhering to all post-treatment care instructions.

**For women of childbearing age:** By signing below, I confirm that I am not pregnant and do not intend to become pregnant during the course of treatment.

**Photography Consent:**
I authorize **☐ Yes / ☐ No** the use of my de-identified photographs for teaching and/or promotional purposes.

**Patient Consent and Signature:**

I have read and fully understand the contents of this informed consent form. All my questions have been answered to my satisfaction. I consent to receive laser treatment.