



THE NADERI CENTER COSMETIC SURGERY SPECIALISTS

Phototherapy BBL (Broadband Light)TM Patient Consent

I understand that the Sciton BBL (Broadband Light) is intended mainly for benign vascular and pigmented lesions and that clinical results may vary in different skin types.

Side Effects and Potential Complications of BBL Treatment

I understand that there is a possibility of rare side effects such as scarring, fat loss, melting of dermal fillers and permanent skin discoloration. There is also the possibility of other side effects such as pain, redness, itching, burning, bruising, swelling, scarring, blistering, hypopigmentation, hyperpigmentation, mottling of skin vascularity and pigmentation, allergic reactions and skin inflammation or irritation. These effects have all been fully explained to me.

I understand that a single procedure will most likely fail to remove my unwanted pigment, vascular or pigmented lesions in the area treated. Multiple treatments are required. Individual response will vary according to skin types, age, skin condition, hair color, and degree of tanning; follow up care, and the body area being treated. Eye injury is possible but unlikely, provided complete eye protection is properly used throughout laser treatment sessions.

I understand the treatment may be painful, but this is typically manageable without any pain medication. Color changes, such as hyperpigmentation (brown/red discoloration) or hypopigmentation (skin lightening), may occur in treated skin. This may take several months to resolve, if at all. Unprotected sun exposure in the weeks following treatments is contraindicated as it may cause or worsen this discoloration. You must notify us of any areas of permanent makeup or Tattoos as well as any medical or dermatologic condition and medications you are on as these may cause complications.

Infection is not usual after treatments; however herpes simplex virus infections around the mouth can occur following treatments. This applies to both individuals with a past history of the virus or individuals with no known history. Should any kind of infection occur, your clinician must be notified to prescribe appropriate medical care.

Contraindication to treatment

I certify that I do not have any of the following conditions, which are CONTRAINDICATIONS to BBL treatment: history of melanoma, raised moles, suspicious skin lesions, keloid scar formation, active infections, open wounds, hives, herpetic lesions, cold sores, tattoos or permanent make-up in area of treatment, recent use of Accutane (in the last 12 months), tetracycline or other antibiotics, or St. John's wort in the last year, autoimmune diseases such as Lupus, Scleroderma, Vitiligo, etc.

I certify that I am not pregnant, trying to get pregnant, or nursing. I have informed my clinician of my recent sun exposure or tan in the last 4-8 weeks and I understand the increased risks of skin discoloration and burns with treatment. I am not tanned the day of my treatment. You must not undergo treatment if you have a tan or been in the sun. You must tell us this.

Financial obligation

I understand that the treatment by the BBL system involves payment, and the fee structure has been fully explained to me. I understand that more than one treatment is often necessary to obtain the desired results and no refunds will be made. I understand individual results will vary and I have to follow strict pre- and post- procedure instructions especially regarding sun avoidance and tans.

With this in mind, I am choosing to proceed with BBL. I have been given the opportunity to ask questions about my condition and the treatment, alternative forms of treatment, risks of the procedures to be used, and the risks and hazards involved, and I have sufficient information to give this informed consent. I certify that I have completely read the above form and I understand its content. I understand that every effort will be made to provide a positive outcome, but that there are no guarantees. I understand the procedure and risks, and accept the risks, and request that this procedure be performed on me at The Naderi Center.

Patient's Name (Printed): _____

Signature: _____ Date: _____ Witness: _____