# *Nemerofsky Plastic Surgery*

## PATIENT CONSENT FORM

FOR THE TREATMENT OF PIGMENTED LESIONS

I hereby authorize Dr. _____Nemerofsky_______or any delegated associates, to perform pigmented lesion treatment with a light based device on me. I understand that this procedure treats pigmented lesions, age spots, and sun spots by targeting melanin with a bright pulsed light. I understand I may not experience complete clearance, and that it may take multiple treatments. Some conditions may not respond at all and, in rare cases, may become worse.

I am aware of the following possible experiences/risks:

- DISCOMFORT – Some discomfort may be experienced during treatment.
- REDNESS/SWELLING/BRUISING – Short term redness (erythema) or swelling (edema) of the treated area is common and may occur. There also may be some bruising.
- PIGMENT CHANGES (Skin Color) – During the healing process, there is a possibility that the treated area can become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- WOUNDS – Treatment can result in burning, blistering, or bleeding of the treated areas. If any of these occur, please call our office.
- INFECTION – Infection is a possibility whenever the skin surface is disrupted, although proper wound care should prevent this. If signs of infection develop, such as pain, heat, or surrounding redness, please call our office __973-784-1024___.
- SCARRING – Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the changes of scarring, it is IMPORTANT that you follow all post-treatment instructions carefully.
- EYE EXPOSURE – Protective eyewear (shields) will be provided. It is important to keep these shields on at all times during the treatment in order to protect your eyes from injury.

The following points have been discussed with me:

- Potential benefits of the proposed procedure
- Possible alternative procedures such as liquid nitrogen, topicals, or excision
- Probability of success
- Reasonably anticipated consequences if the procedure is not performed
- Most likely possible complications/risks involved with the proposed procedure and subsequent healing period
- Post-treatment instructions

For women of childbearing age: By signing below I indicate that I am not pregnant. Futhermore, I agree to keep Dr.__Nemerofsky___and staff informed should I become pregnant during the course of treatment.

Photographic documentation will be taken. I hereby do___do not___authorize the use of my photographs for teaching purposes.

### ACKNOWLEDGMENT

**BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS PERMISSION FORM FOR LIGHT BASED TREATMENT OF MY PIGMENTED LESIONS, AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.**

| ____________________________ | ______________________ | ____________________ |
|---|---|---|
| **Signature-Patient or Guardian** | **Print Name/Relationship** | **Date** |
| ____________________________ | ______________________ | ____________________ |
| **Signature-Witness** | **Print Name** | **Date** |

Revised 12/8/06