FLATIRONS DERMATOLOGY

CO2 Therapy Consent Form

Patient: _____DOB: _____Date: _____

Treatment Sites: _____

I duly authorize Dr. Christopher Smith to use the CO2-laser system to perform ablative skin resurfacing and any post treatment medical requirements that may be necessary.

I understand that the CO2 is a procedure performed with a laser device designed for ablative skin resurfacing and that clinical results may vary in different individual skin types. I understand there is a possibility of short-term effects such as reddening, blistering, scabbing, temporary bruising, and temporary discoloration of the skin as well as rare side effects such as scarring and permanent discoloration. These effects and risks have been fully explained to me.

Clinical results may vary depending on individual factors including medical history, amount of sun damage (or textural problems), skin type, patient compliance with pre/post treatment instructions, and individual response to treatment.

I understand that CO2 may involve a series of treatments and the fee structure has been fully explained to me.

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I am not pregnant at this time, and that I have not taken Accutane within the last 12 months. I do not have a pacemaker or internal defibrillator. I also have completed a medical history checklist and have been informed about what I must do and "not do" before, during, and after the procedure.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education, and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of the consent form.

Patient Signature: _____Date: _____

Witness: _____Date: _____

Dr. Christopher Smith M.D.
13605 Xavier Lane, Suite B, Broomfield, CO 80023 or 4075 E 128th Ave., Thornton, CO 80241
303.404.3376