FAMILY VISION CARE OF KINGSTON
PATIENT CONSENT FOR OPTILIGHT/IPL PROCEDURE

Please read and initial each statement. Complete, underline or circle individual selection accordingly.

The primary reason for your treatment is the improvement of Dry Eye signs and symptoms. You should know the IPL is also used and has been shown to reduce red and brown spots on the skin. The intent of your treatment is solely to improve the signs and symptoms of dry eye through this non-laser, non-surgical light treatment.

- I authorize Doctor _____ to perform IPL™ in an effort to improve my dry eye signs and symptoms. **Initial** _____

- I understand that there is a rare possibility of side effects or serious complications including permanent discoloration and scarring of the treatment area and adjacent tissue. I am aware that careful adherence to all advised instructions will help reduce this possibility

Initial _____

I understand the following list below of short-term effects and agree to follow matching guidelines:

- Flaking of pigmented lesions – crusts may take 5 to 10 days to disappear and it is important not to manipulate or pick these lesions. As this may otherwise lead to scarring.
- Discomfort – during the procedure, I might experience a sensation similar to a rubber band snap on the skin. The degree will vary per my skin condition and area being treated. I will let the Doctor know if the degree of treatment is uncomfortable, unwanted, or providing more than transient discomfort. A mild "sun-burn" sensation may follow for typically up to one hour and can be reduced with cooling creams or ice applied to the treatment area. This is not part of the pos-treatment care but may be done safely if needed.
- Reddening and swelling – severity and duration depends on the intensity of the treatment, skin type, and location treated. These phenomena may be reduced with application of cooling and/or inflammatory creams as directed by your doctor if needed.
- Bruising may rarely occur and may last up to 2 weeks and will be more likely if I am on any type of blood thinning agent

Initial for all the above _____

I understand that sun exposure or tanning of any sort is not aligned with the pre and/or post-care instructions and may increase the chance for complications. **Initial** _____

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The procedure as well as potential benefits and risks have been thoroughly explained to me and I have had all my related questions answered. **Initial** _____

Pre and post-care instructions have been discussed and are completely clear to me
Initial _____

I understand that results may vary with each individual and acknowledge that it is impossible to predict how I will respond to the treatment and how many sessions will be required. Hazleton and Stroudsburg Eye Specialists recommends at a minimum 4 consecutive treatments spaced two to three weeks apart for optimal results
Initial _____

I consent to photographs being taken for the purpose of documenting my progress and response to the treatment and be kept solely in my medical record. **Initial** _____

I consent to photographs of the treatment zone ONLY being used for the purpose of practice marketing materials including, television, paper, pamphlets. Social media, as well as website use. In these photos patient identifiers will be removed such as any full face photo **Initial** _____

I consent to photographs being used for medical education or publication with applied discretion and not revealing my identity. **Initial** _____

I agree to review the following IPL™pre-treatment compliance checklist along with my Doctor and bring accurate and updated data, to the best of my knowledge
Initial _____

My signature certifies that I have duly read and understood the content of this informed consent form, and gave the accurate information as to my health condition. I hereby freely consent to IPL treatments.

_____	_____	_____
Name of Patient (please patient)	Signature of Patient	Date

_____	_____	_____
Name of Witness (please patient)	Signature of Witness	Date