Redwood Family Dermatology

Jeffrey Sugarman, MD, PhD Albert Peng, MD Ligaya Park, DO Judith Hong, MD
Andrea Austin, MD Jennifer Hayes, MD Brianne Dickey, MD Stephen Schwartz, MD
Angela Wyble, PA-C Angela Abboud, PA-C Heather Lowe, PA-C Tatiana Longoria, RN

2725 Mendocino Avenue – Santa Rosa, CA 95403 – (707) 545-4537 – (707) 545-6726 fax
555 South Dora Street – Ukiah, CA 95482 – (707) 462-3996 – (707) 462-3363 fax
4727 Hoen Ave, Ste. A – Santa Rosa, CA 95405 – (707) 527-0342 – (707) 527-0818 fax

Consent to Cosmetic Procedure(s)

I authorize my provider _____ to perform the following procedure(s):

--V Beam Laser--Laser Hair Removal --IPL --ResurFx --Q Switch Yag --ND Yag --Microneedling

I have received the information packet (s) explaining the risks and complications specifically associated with the above procedure(s). **Initials: _____**

I understand the treatment may also include, but is not limited to the following reactions/complications or side effects: abrasions, bruising, blistering, redness, scarring, swelling, and pigment changes in treated skin. Eye injury is possible, but unlikely, providing that complete eye protection is properly used throughout treatment sessions. I understand that by following all procedure guidelines, the risk of these occurrences are greatly diminished but are still possible.

Anesthesia is usually not necessary. If the provider or I elect to use a form of anesthesia, all options will be discussed with me in advance. I understand the treatment may be painful, but this is typically manageable without prescription pain relief medication.

I understand that multiple treatments may be required and that no guarantee, warranty or assurance has been given to me as to the results that may be obtained. Additionally, I understand that this is completely elective and will not be covered by my insurance company. I agree to pay a fee for every treatment and understand that there is no guarantee that I will achieve complete satisfaction. I understand that there is no money back guarantee for this cosmetic procedure.

I authorize the providers and/or staff of Redwood Family Dermatology to photograph me while under their care. I understand that these photographs will be used as part of my medical record.

I authorize the providers and/or staff of Redwood Family to use my photographs for medical research, teaching, publication in a medical article or text book, as part of a scientific exhibit, to illustrate medical lectures given to medical students or other medical professionals or groups and/or social media. I understand I will not be identified by name in any use of these photographs. **Initials: Agree_____Decline_____**

I waive any right to compensation for the above uses. I hold Redwood Family Dermatology, the attending providers, and their designees harmless from and against any claim for injury or compensation resulting from the activities authorized in this agreement.

I understand and adhere to all safety precautions and regulations during the procedure and agree to follow the provider's and staff's post procedural instructions. I fully understand the terms within the above consent and wish to proceed with the procedure. All of my questions have been addressed to my satisfaction. In the event a dispute arises over the outcome of my procedure, I consent solely to arbitration as a legal means of settlement. **I can read and understand English, or if I do not, I have appointed, or been appointed someone to translate this consent form in its entirety.**

_____ _____ _____
Patient Name (please print) DOB Parent Name (if patient is a minor)

_____ _____ _____
Signature Date Parent Signature (if patient is a minor)

_____ _____
Witness Signature Language Translator (if applicable)

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