Kure Med Spa, LLC

PATIENT INFORMED CONSENT FORM FOR ACNE TREATMENT

I hereby authorize Kure Med Spa., LLC staff to treat me for acne. This permission form is intended to be a tool to ensure that you have been informed about your procedure, the risks and benefits, and to provide you with a chance to ask any questions you may have.

Acne treatment is a gradual process. Most individuals require 8-12 sessions to reduce the acne. The light is pulsed over the face and it feels like a mild rubber band snap. After a procedure the skin is often pink in its appearance, and there can be some mild transient worsening of the acne before it improves. Before and after a treatment, we would ask you to strictly avoid tanning for 4 weeks. ____ **initial**

There are a few risks with any light based treatment. The majority of individuals have no problem with the treatments. Up to 5% of people may experience bruising - which can be very deep purple for a week or sometimes a little longer. Uncommon side effects would include blistering and pigmentation changes. Rare/unexpected risks would include scarring. For men, there is a concern that the light emitted may reduce their beard hair. ____ **initial**

Many acne medications cause the skin to be sensitive to light. Please remind the staff at every visit about your medications. We will likely request that you stop taking your oral medications and creams several days before each treatment. If you have taken a drug called **Accutane** within the last year, you must inform the staff immediately, as this medication may leave you light sensitive for an extremely long time and we do not wish to burn you with the light treatments. If you took **Accutane** we must delay your treatment. This is for your safety. ____ **initial**

For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become pregnant during the course of treatment. Furthermore, I agree to keep Kure Med Spa, LLC 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 and/or advertising purposes.

ACKNOWLEDGEMENT

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FOR THE PROCEDURE AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.

_____	_____	_____
Signature Patient/Guardian	**Print Name/Relationship**	**Date**
_____	_____	_____
Signature - Witness	**Print Name**	**Date**