Juliet™

Laser Treatment For Vaginal Health

Juliet Laser for Aesthetic Skin Resurfacing

***(NOTE: THIS PATIENT INFORMED CONSENT TEMPLATE IS PROVIDED "AS IS" AND IS INTENDED FOR INFORMATIONAL PURPOSES ONLY. THIS TEMPLATE MAY NOT MEET ALL STATE AND FEDERAL LEGAL OR REGULATORY REQUIREMENTS FOR USE WITH PATIENTS. PHYSICIANS USING THIS TEMPLATE ARE RESPONSIBLE FOR ENSURING THE INFORMED CONSENT FORM USED WITH PATIENTS MEETS ALL APPLICABLE STATE AND FEDERAL LEGAL AND REGULATORY REQUIREMENTS, AND ARE ENCOURAGED TO CONSULT WITH THEIR ATTORNEY.)**

I hereby authorize Dr.________________________ or _______________________, under Dr. _____________________’s supervision to perform the Juliet Laser treatment. The Juliet is an Er:YAG 2940 nm laser for the purpose of skin peeling, resurfacing and/or skin revitalization. It may take multiple treatments to obtain optimal results, and it is possible that the results will be minimal or not help at all. The results may be temporary or permanent and there is no way to predict how long the results will last. Although these devices are effective in most cases, no guarantees can be made.

The procedure may result in the following adverse experiences or risks:

- **DISCOMFORT/PAIN –** Some discomfort and/ or pain may be experienced during treatment. A topical anesthetic will be applied to your skin before treatment. Other forms of anesthesia, or pain management, may also be used.
- **SWELLING –** Swelling (edema) of the treated area is common and may occur. This usually resolves in a few days.
- **REDNESS –** Redness (erythema) of the treated area is common and may occur. This usually resolves in a few days.
- **SKIN COLOR CHANGES –** During the healing process, there is a possibility that the treated area may 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. You should avoid sun exposure after the treatment and use sunblock.
- **MILIA/ACNE –** Ointments that occlude hair follicles, sweat ducts, or sebaceous ducts may lead to milia/acne formation. This is more common in individuals with a history of cystic acne or oily skin.
- **WOUNDS –** Treatment can result in burning, blistering, or bleeding of the treated areas. It is important that you not pick or scratch the sites as this may lead to permanent scars or promote an infection. If any of these occur, please call our office.
- **INFECTION –** Infection is a possibility whenever the skin surface is disrupted which can lead to scarring. Proper wound care and keeping the treated area clean are important. If signs of infection develop, such as pain, heat, blisters, or surrounding redness, please call our office __(Phone number)_______.
- **CONTACT/ALLERGIC DERMATITIS OR SKIN SENSITIVITY –** Potential increased sensitivity, irritation/itching or allergic reaction of the skin due to skin surface disruption.
- **SCARRING –** Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.
- **TREATMENT PATTERN –** A persistent spot size pattern may be apparent on the treated skin and usually resolves with time. In rare cases, it may be permanent.
- **ALLERGY –** There is a risk of an allergic reaction to the numbing cream.
- **SUN EXPOSURE / TANNING BEDS / ARTIFICIAL TANNING –** May increase risk of side effects and adverse events.

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- **EYE EXPOSURE –** Protective eyewear (shields) will be provided to you during the treatment. Failure to wear eye shields during the entire treatment may cause severe and permanent eye damage.

I acknowledge the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me
- Alternative treatments
- Reasonably anticipated health consequences if the procedure is not performed
- Possible complications/risks involved with the proposed procedure and subsequent healing period
- Post-treatment care instructions

For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep Dr.__________________________ and staff informed should I become pregnant during the course of treatment.

Photographic documentation may be taken. I hereby ☐ do ☐ do not authorize the use of my photographs for teaching purposes.

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

______________________	______________________	______________________
Signature-Patient	**Print Name**	**Date**
______________________	______________________	______________________
Signature-Witness	**Print Name**	**Date**

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