ISOLAZ
CONSENT FORM

Lantry Laser & Skin Care Center
Also referred to as the Lantry Laser Center

Patient Name_____

Date of Birth_____ Male____Female____

This consent form is designed to provide you with information about the Isolaz system for acne treatment. Please take the time to carefully and fully read this consent form.

Medical History Disclosure

I understand that Dr. Selena Lantry has asked me to complete a medical history form. If there are any issues that are not covered by the medical history form that I think are relevant to my treatment, I will inform Dr. Lantry prior to my Isolaz treatment.

I will also notify Dr. Lantry of any changes in my health or medical care as they occur during my treatment program. In addition, I will inform Dr. Lantry of all medications, drugs and other products that I currently take or begin taking during treatment, including but not limited to: prescription medications (including birth control pills), over-the-counter medications, herbs, supplements and vitamins. I understand that any failure to do so on my part may affect the results of my treatment and/or increase the likelihood of side effects or post-treatment complications.

Description of Procedure

The Isolaz System uses photopneumatic technology (vacuum energy and broadband light) to treat mild to moderate acne, pustular acne, comedonal acne, mild to moderate inflammatory acne and acne vulgaris. Isolaz uses a treatment tip that applies gentle vacuum pressure to draw the skin to be treated into the handpiece of the system. This "pulling up" motion brings the acne closer to the surface of the skin. Broadband light energy is applied to the skin which is then converted into heat energy and absorbed by the skin to destroy the acne.

Potential Side Effects and Risks

I understand that there are potential side effects and risks associated with my treatment. I understand that these include, but are not limited to, pain, scarring, bruising, swelling, redness, blistering, hyperpigmentation and hypopigmentation. I can minimize these side effects and risks

by strictly adhering to the post-treatment care instructions given to me at the Lantry Laser Center.

I also understand that the light-based technology used in the Isolaz system creates a potential risk of eye damage. To minimize this risk, the Lantry Laser Center will provide me with appropriate protective eyewear for my use during the treatment.

Results Not Guaranteed

I understand that the results of my treatment cannot be guaranteed. I understand that my results may vary based on the following factors: skin type, area of body being treated, natural hair color, post-treatment care, follow-up care and tanning by sun exposure or self-tanning products. I understand I may require multiple treatments in order to obtain the desired results. I will strictly adhere to the post-treatment care instructions given to me by the staff at the Lantry Laser Center.

Informed Consent

I understand that this Informed Consent shall remain in effect as long as the Lantry Laser Center continues to provide me with the treatments described in this document.

By signing below I acknowledge and agree that:

- I have read, fully understand and agree to the contents of this Informed Consent.
- The treatments described in this Consent and the potential side effects and risks have been satisfactorily explained to me.
- I have been given an opportunity to ask any questions that I might have, and all of my questions have been answered to my satisfaction.
- I hereby give my voluntary informed consent to the performance of treatments.

_____ _____

Patient Signature Date

If the patient is under the age of 18, a parent or guardian must sign below.

_____ _____

Parent/Legal Guardian Signature Date