# SMARTXIDE DOT LASER CONSENT FORM

I have agreed to have Valerie Barrett, MD of RENU Medical Aesthetics perform fractionated laser treatment with the SmartXide laser, a fractionated CO2 laser, on me today. I have been informed that I may have to undergo multiple treatments before maximal results are achieved. I am aware there will be a low amount of discomfort during the procedure.

I have been informed of the post treatment care and agree to be compliant with these instructions. I understand that if I fail to follow these instructions I will risk scarring and infection. _____

I have been informed that if I have a history of cold sores, I must inform RENU Medical before my first treatment. I affirm that I am not breastfeeding, pregnant, or have any medical conditions such as diabetes or altered immune state (on steroids, chemotheraphy, etc.) that would interfere with healing. _____

I am not a smoker or have stopped smoking for 30 days and agree not to continue smoking for at least 90 days after the procedure. _____

I have been informed of the possible procedure risks and complications such as prolonged redness, swelling, hypo/hyperpigmentation, scarring, keloid formation, blistering, infection and bruising. I also understand and agree that if I have any concerns or problems such as mentioned above, I will notify Dr. Barrett at 772-834-3231 immediately. _____

I have received the preoperative instructions to follow before the procedure and the post treatment instructions and agree to abide by the care instructed by Dr. Barrett.

I have read and fully understand the instructions and risks and authorize Dr. Barrett to perform the fractionated laser procedure on me. All my concerns and questions have been adequately addressed. I understand that I have other options including no treatment.

Patient signature _____ Date_____

Patient name (printed) _____

Physician signature _____