



CENTER FOR  
REGENERATIVE HEALTH

**Informed Consent for PicoSure Pigmentation and Tattoo Treatment**

The PicoSure laser produces an intense burst of light that is absorbed by the pigmented lesion or tattoo ink.

All personnel in the treatment room, including me, will wear protective eyewear to prevent eye damage from this intense light.

The sensation of the laser light on skin is uncomfortable and may feel like a slight pinprick or the sensation of heat. These sensations may last for a few hours.

Prior to the treatment, test spots may be performed. Test spots help to determine effective treatment settings.

Tattoos may blister and have pinpoint bleeding for a few days after treatment.

Following a pigment treatment, the treated areas may be red, slightly swollen; pigment may darken and slough off in 7-10 days.

The area should be treated delicately following treatment. Do not pick on scabbing/blistering.

Multiple treatments may be necessary.

I have been informed that hyperpigmentation (darkening of the skin), and hypopigmentation (lightening of the skin) are possible complications of the procedure and incidence of this occurring are higher for darker skin types **Yes**  **No**

I understand that sun exposure, as well as not adhering to the posttreatment instructions provided to me may increase my chance of complications.

I agree to have before and after pictures taken of the area to be treated: **Yes**  **No**

I have read and understood all information presented to me, and I have been given an opportunity to ask questions before signing this consent.

Consent for treatment of \_\_\_\_\_

Patient: \_\_\_\_\_ Date \_\_\_\_\_  
(or legal guardian)

Witness: \_\_\_\_\_ Date \_\_\_\_\_



CENTER FOR  
REGENERATIVE HEALTH

**Informed Consent for PicoSure Focused Treatment**

The PicoSure laser using the Focus lens array produces an intense burst of light. All personnel in the treatment room, including myself, will wear protective eyewear to prevent eye damage from this intense light.

Prior to the treatment, test spots may be performed. Test spots help to determine effective treatment settings.

The sensation of the laser light on the skin may feel like a slight pinprick or the sensation of heat. The sensation of heat may last for an hour or longer after the treatment. Cold air or a cool gel pack may be used during treatment or posttreatment to cool the skin and to minimize warmth. You will also hear a slight snapping sound during the treatment and feel the touch of the laser distance gauge (part of the device) in the treated area.

Following the procedure, you may have redness or slight swelling in the treated area; this may last for 24 hours. You may also develop an acne-like breakout or slight darkening of the pigment; it should resolve without intervention in 3-7 days.

The area should be treated delicately following treatment. Multiple treatments may be necessary.

Posttreatment:

- Cool the skin posttreatment as needed with cold gel packs, aloe vera gel, or cool air.
- Wash the treatment area gently with soap and water; do not soak the treated areas.
- Apply moisturizer for sensitive skin.
- Do not shave the treated area if crusting is evident
- Avoid sun exposure between treatments. If sun exposure is unavoidable, use a 30+ sunblock to protect exposed, treated areas.
- For patients who are prone to break outs or have sebaceous skin, consider waiting 24 hours before applying any topical products

I have been informed that hyperpigmentation (darkening of the skin), and hypopigmentation (lightening of the skin) are possible complications of the procedure and incidence of this occurring are higher for darker skin types: **Yes**  **No**

I understand that sun exposure, as well as not adhering to the posttreatment instructions provided to me may increase my chance of complications.

I agree to have before and after pictures taken of the area to be treated: **Yes**  **No**

I have read and understood all information presented to me, and I have been giving an opportunity to ask questions before signing this consent.

Consent for treatment of \_\_\_\_\_

Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
(or legal guardian)

Witness: \_\_\_\_\_ Date: \_\_\_\_\_