CONSENT FOR FRAXEL RE:PAIR

1. I hereby authorize Steven M. Rotter, M.D. to perform Fraxel Re:pair (Laser resurfacing) upon me on or about the _____ of _______________ 20____ , for the purpose of trying to improve the appearance with respect to the following condition(s):
   ____
   ____

2. The effect and nature of laser surgery, risks involved, as well as possible alternative methods of treatment (including scar excision, chemical peeling, soft tissue augmentation such as fat transplantation and juvederm injection, dermabrasion, and not to perform laser surgery) have been fully explained to me. Initials (_____)

3. I know that permanent scarring can occur and that persistent redness may signal the onset of this scarring. I know that I must inform Dr. Rotter of this redness immediately as early treatment may lessen the severity of the scarring. Scarring may occur from crusting, infection, or simply being exposed to laser. Initials (_____)

4. I know that my skin in the treated area will be pink. I know that this pinkness may last for many months and that I must avoid sun exposure during this time. Initials (_____)

5. I know that permanent lightening of the treated skin is common. I also know that blotchy darkening may occur which may resolve with treatment or time. Initials (_____)

6. I know that other risks include bacterial infection, viral infection (e.g. herpes), the formation of tiny cysts, ectropion (a downward pull of the eyelid for treatment around the eye area) and failure to achieve the desired results. Initials (_____)

7. I also authorize Dr. Rotter to perform any procedure which he may deem necessary or desirable in attempting to improve the condition stated above (in paragraph 1), or any unforeseen condition. Initials (_____)

8. I know that the practice of medicine and surgery is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee has been made by anyone regarding the operation I have requested and authorized. Initials (_____)

9. I acknowledge I have not used Accutane or any generic for the past 18 months. Initials (_____)

10. In the event that one of our health care professionals, workers or employees should be directly exposed to your blood or body fluids (needlestick/splash to mucous membranes), your blood will be drawn and tested for HIV, Hep B, Hep C and Syphilis. Initials (_____)

Signed:____Date: ______________
(Patient or person authorized to give consent)

Witness:_______________________________________Date: ______________