SANTA MONICA EYE MEDICAL GROUP

ALMA TED Consent Form

1. Reason for Procedure: I am seeking treatment for the following condition: **Hair Loss**

2. The Procedure. I have requested that the undersigned physician at the Clinic perform the following procedure (the "Procedure"): **ALMA TED**

3. Risks. There are risks related to the performance of this Procedure. I understand and acknowledge that the risks associated with this particular Procedure may include the following:

    - Discomfort and pain – I acknowledge that I will experience some discomfort during and after the Procedure. Long term pain after completion of the procedure is a possible but rare side effect.
    - Infection – Although rare, infection is a possibility any time a Procedure is performed. It is possible, but rare, for an infection to spread in the body. If an infection spreads, that could require hospitalization.
    - Blood clots in veins and lungs –The Procedure could cause blood clots. Blood clots that travel to the heart or lungs could cause to an emergency medical condition.
    - Allergic reactions –I could possibly develop an allergic reaction to medicines applied to the treated area and that I could possibly develop an allergic reaction to any medications that may be prescribed for me. I have discussed all known allergies with my treating physician.
    - Bruising – Bruising in the treated area is possible, especially if, within the last ten (10) days, I have taken aspirin or aspirin-containing products, or other medications that "thin" the blood. I will discuss any medications I am taking with my doctor.
    - Blindness and eye damage – If I am not wearing protective eyewear, the laser used in the Procedure could visual loss, including blindness. I understand that I will be provided with protective eye shields. I acknowledge that it is important to keep these shields on at all times during the Procedure and that I should also keep my eyes closed in order to protect my eyes from accidental laser exposure.
    - Painful or unattractive scarring – Scarring is a rare complication of laser assisted treatment, but scarring is possible. To minimize the chances of scarring, it is most important that I follow all instructions carefully after my procedure.
    - Pigment changes (skin color) – During the healing process, the treated area may become either lighter or darker in color than the surrounding skin. This is usually temporary, but on a rare occasion, it may be permanent.
    - Poor healing – An open wound may require more than the usual one to three weeks to heal. This could require further treatment.

4. Other Medical Conditions. My doctor and the Clinic staff need information about my health history in order to perform the Procedure. **Please initial where indicated below:**

- Pregnancy. The Procedure is not suitable if you are pregnant.
- Age. The Procedure should not be performed on pages in certain age groups. I am between the ages of 25 and 65. ____

- Pap smear and pelvic Exam. I have had a Pap smear and a pelvic exam within the past 30 days, the results of which have been provided to the Clinic. ____
- Oral antiviral medicine. If applicable I have taken prophylactic oral antiviral agents for the prevention of Herpes Simplex Virus. ____
- Other. I have had other health warnings explained to me by the Clinic and I agree that none of those warnings apply to me. I agree to comply with all precautions recommended by my Doctor.

5. No Guarantee of Success. I acknowledge that no guarantees have been made to me as to the results that will be achieved. It is possible that multiple Procedures may be required and that even then success might not be achieved.

6. Consent to Photography. For the purposes of accurate record keeping in connection with the care and treatment which I am receiving and will subsequently receive from the Clinic, I hereby consent to have the Clinic's staff take before, during, and after treatment close-up photographs of the involved area (s) and the anatomical region surrounding the involved area (s). These photographs shall be used for medical records only and shall be treated with the same confidentiality as the remainder of my records at the Clinic. I have been given an opportunity to ask questions about my condition, alternate forms of anesthesia [*if applicable*] and treatment, the procedure to be used, and the risks and hazards involved. My doctor has answered all of my questions.

I believe that I have sufficient information to consent to treatment.

By signing below, I certify that I have read and understand this document.

I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian having legal custody will also be required before treatment.

I voluntarily consent and authorize that this Procedure to be performed.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Patient Signature_____ Date_____

Surgeon Signature_____

Witness_____