

**TATTOO LASER CONSENT FORM**

The procedure planned in the treatment of a decorative tattoo with the Q-Sitch Medlite Nd:YAG Laser using local, topical, or no anesthesia. The purpose of this procedure is to attempt removal of the tattoo or to make the decorative pattern as unrecognizable as possible by lightening the pigment pattern.

Alternative treatment methods include camouflaging with make-up, tattooing over with a second tattoo, abrasive treatments, acid treatments, treatment with a CO2 laser, cutting out (with tissue expansion or skin grafting if needed), or no treatment at all.

I understand that the risks of the procedure include possible pain, bleeding, infection, scarring, drug reactions and unforeseen complications. There is also the risk of patchy residual pigment, persistence of tattoo pattern, change or permanent lightening of skin color, change in skin texture, or hair loss or thinning. Previous treatment by any method may increase any or all of these risks.

I understand that this procedure fails to remove all pigment in some cases, especially with professional applied tattoos, and may not be effective on certain pigments. Laser treatment of whit or flesh colored tattoos can cause dark brown/black color change. Multiple treatments are generally required. I understand my responsibility for properly fulfilling the appropriate aftercare instructions as explained by the doctor, his staff, and/or written or videotaped instructions provided

I further agree that any photos or videotape taken of me may be used for other teaching or publication, if considered appropriate, unless I notify the doctor in writing that he/she may not use these photographs in such a manner.

The procedure is generally considered cosmetic, and is not covered by insurance. I understand that I am responsible for all costs of treatment(s).

I have been asked at this time whether I have any questions about this procedure and I do not have any further questions. I understand the procedure, accept the risks, and request that this procedure be performed on me by the doctor and his/her assistant.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

I understand and acknowledge that all fees paid to Dr. Roham are non-refundable and I agree to these terms and I will not receive a refund or chargeback.

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Patients Initials