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Πάφος
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CO2 Laser and Electrocautery Consent Form

I authorize Dr. Neofytou Yiannis to perform CO2 laser treatments on me. I understand this is a purely elective procedure, that results may vary with each individual, and that multiple treatments may be necessary. **Initials _____**
I understand that there is a possibility of rare side effects, such as scarring, permanent discoloration, as well as short-term effects such as reddening, mild burning, temporary bruising and discoloration of the skin. These effects have been fully explained to me. **Initials _____**

1 Serious complication is rare but possible.
2 Common side effects include temporary redness and mild sunburn-like effects that may last from a few hours to a few days. The treated area may remain red and swollen for 2 – 72 hours. Rarely, veins and vascular areas may initially appear dark red to purple in color.
3 Pigment changes, including hypo-pigmentation (lightening of the skin) or hyper-pigmentation (darkening of the skin) lasting from 1 – 6 months or longer may occur, especially if you are not compliant with sun protection during therapy.
4 Other potential risks include crusting, itching, pain, bruising, burns, infection, scabbing, scarring, swelling and failure to achieve the desired results.
5 Laser light could cause serious eye injury; protective eyewear must be worn during treatment.
6 I understand that sun or tanning lamp exposure, and not adhering to the pre-care and post-care instructions may increase the chance of complications, may increase healing time, and may decrease obtaining optimal results.

I also understand that there are other options for treatment available and each of these other treatments has been fully explained to me. **Initials _____**
I consent to photographs being taken to evaluate treatment effectiveness, for medical education and training. **Initials _____**
I understand that the treatment involves payment at the time of service and the fee structure has been fully explained to me. **Initials _____**
For women of childbearing age: By signing below I indicate that I am NOT pregnant. Furthermore, I agree to keep Dr Neofytou Yiannis informed should I become pregnant during the course of treatment. **Initials _____**
Pre-treatment and aftercare instructions have been discussed with me. The procedure as well as potential benefits and risks have been explained to my satisfaction. I have had all of my questions answered. I freely consent to the proposed treatment.

PATIENT SIGNATURE:

____
DATE:
____

PHYSICIAN SIGNATURE:

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DATE:
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