TRU ESSENCE SPA
An AccuHealth Company

Disclosure and Consent

- I (we) voluntarily request laser/light assisted treatment for vaginal remodeling/treatment of stress urinary incontinence

- I (we) voluntarily consent and authorize that this laser/light assisted treatment be performed by the staff of this clinic, including physicians, technicians, associates, technical assistants, and other health care providers as deemed necessary by the staff of this clinic.
- I (we) hereby release this clinic, its staff, and any other participating health care providers from any and all liability for any adverse effects that may result from this treatment and related procedures.
- For the purposes of accurate record keeping in connection with the care and treatment which I am receiving and will subsequently receive from this clinic, I (we), the undersigned, consent to have this 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 and shall be treated with the same confidentiality as the remainder of my record at this clinic.
- I (we) recognize that this laser/light assisted treatment is not an exact science and I (we) acknowledge that no guarantees or assurances have been made to me (us) as to the result or cure. There are risks related to the performance of these procedures. I (we) understand and acknowledge that the risks that may occur in connection with this particular procedure may include the following:
  1) Infection – Albeit rare, skin infection is a possibility any time a skin procedure is performed. I acknowledge and understand that although rare, it is possible for a skin infection to become a blood-borne widespread infection.

2) Blood clots in veins and lungs –Albeit extremely rare, it may be possible to develop a blood clot associated with this treatment that goes (embolizes) to the heart and/or lungs.
3) Allergic reactions – Although uncommon, 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.
4) Hemorrhage and bruising – Bruising in the treated area is possible, especially if, within the last ten (10) days, I (we) have taken aspirin or aspirin-containing products, or other medications that "thin" the blood.
5) Recurrence of the lesion – I may not experience permanent results even with multiple treatments.
6) Painful or unattractive scarring – Scarring is a rare complication of laser assisted treatment, but scarring is possible because the skin surface is disrupted by the laser. To minimize the chances of scarring, it is most important that I follow ***all postoperative instructions*** carefully.
7) Discomfort and pain – Some discomfort will be experienced during and after the laser treatment. I give my permission for the administration of topical and/or local injection of anesthesia when and if deemed appropriate.
8) 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.
9) Poor healing – The resultant open wound may require more than the usual one to three weeks to heal.
10) Blindness and eye damage – The laser, without protective eyewear, may cause visual loss including blindness. ***It is important to keep these shields on at all times*** during the procedure and that I ***should keep my eyes closed*** in order to protect my eyes from accidental laser exposure.

- I (we) understand and acknowledge that I have been informed by means of visual aids, as well as individual discussion, that multiple treatments are often required to cause long-term results and that some patients have no results even with multiple treatments. The usual number of treatments required is two to three, but more treatments may be required.

- I (we) have been given an opportunity to ask questions about my condition, alternate forms of anesthesia and treatment, the procedure to be used, and the risks and hazards involved, and I (we) believe that I (we) have sufficient information to give the informed consent. By signing below, I (we) certify that I (we) have read and fully understand the contents of this document and that I (we) have received and understand all of the disclosures referred to herein. 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.

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Signature of Patient Signature of Person Authorized to Consent for Patient

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Print Name of Patient Print Name Relationship

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Post Laser/Light Treatment Care

1. Be careful with hot water and do not bathe with very hot water until healed.
2. Keep the area moist with Aloe Vera gel, or Aquaphor Healing Ointment until inflammation resolves and the area is healed.
3. Keep clothing from rubbing the treated area and avoid other irritation to the area.
4. Notify the clinic should you have any prolonged redness, excessive puffiness, or other unusual side effects.

Important Facts to Remember

1. There will be redness, and occasionally, mild blistering of the treated areas lasting for several hours to 3 - 14 days.
2. The treated area might "crust", "flake", or look like a "cat scratch". This should resolve within 3 - 14 days.
3. Each area to be treated usually requires two or more treatments approximately 2-12 weeks apart.
4. It might be impossible to remove the lesion forever. Even though the lesion may be diminished or "disappear" for long periods of 3-6 months, it might return in the future. The fact that the lesion responded to treatment and was disabled for an extended period almost invariably means it will respond to future treatment.

Signature of Patient Signature of Person Authorized to Consent for Patient

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Print Name of Patient Print Name Relationship

Date