



## ***Consent Form for Tattoo Removal Treatment***

### **Explanation of Treatment**

The laser is a form of light that specifically targets tattoo pigment in the skin. The tattoo pigment absorbs the laser light and is broken up into small fragments. These tiny fragments of pigment are then absorbed by the body naturally in **4-8** weeks following the treatment. It can typically take **12-15** sessions of laser treatment to remove a tattoo, however results vary due to different skin types, types of inks, colors, application of inks, age of inks etc. With laser tattoo removal it is normal to experience inflammation of the skin that may become red, swollen, crusted and occasionally blister or bleed. This reaction typically lasts a few days and can be helped by applying a thin layer of **Aloe Vera**, or Vitamin E gel, a Polysporin ointment can be applied 4 times daily to the treated area if the outer layer of the skin has been disturbed causing broken skin.

### **Possible Risks Associated with Laser Tattoo Removal**

- Pain associated with the laser light – typically like hot bacon grease hitting the skin
- Skin redness and swelling of the skin surface that typically lasts several days
- Crusting of the surface of the skin and blistering or bleeding from treatment area is common
- Loss of color of the skin, or hypo pigmentation.
- Risk of hypertrophic or keloid scar that may be permanent
- Small risk of permanent scarring, typically a white mark
- Risk of failure of the treatment to remove the tattoo

### **Patient Consent**

- **I agree** to the procedure described above and by my tattoo removal specialist
- **I agree** that I will wear eye protection during treatment sessions and will not look directly at the laser while in operation
- **I understand** that the results of treatment may vary with each individual and that the success of treatment can never be guaranteed
- **I understand** that there may be side-effects that can include reddening of the skin, bruising, mild burning or blistering, and very rarely scarring
- **I understand** that multiple treatments may be required to achieve the desired result

**I have read and understand all of the above information and hereby give my permission to proceed with treatment(s) as recommended.**

**Full Name:** \_\_\_\_\_ **D.O.B :** \_\_\_\_\_  
(Please Print) mm/dd/year

\_\_\_\_\_  
**Patient Signature** **Date** mm/dd/year