PATIENT CONSENT FORM

LASER TREATMENT FOR FUNGAL NAILS

I hereby authorize and provide permission to perform an Aspen Class IV Laser treatment for the treatment of fungal nails.

I understand that the Aspen Class IV Laser treatment for fungal nails is a safe and noninvasive treatment and has been cleared by the FDA for the temporary increase of clear nail in patients with onychomycosis (e.g., Dermatophytes Trichophyton rubrum and T. mentagrophytes, and/or yeasts Candida albicans, etc.). The laser energy penetrates the nail and destroys the fungus and other organisms in and under the nail plate. The laser has no effect on skin or soft tissue. As with any procedure, there is some risk of side effects.

I understand that my nail may be debrided prior to the laser procedure to allow the laser energy to better penetrate the nail.

I understand that the clinical results may vary in different patients and that there is no promise or guarantee regarding the results of the treatment, and that to achieve maximum clinical results, I may need multiple treatments. I understand that the fungus may not be completely destroyed and that the nail may become re-infected or that there may be other types of infections present for which the laser may not be an effective treatment. The nail may continue to be discolored or not attached to the nail bed. This treatment will not change the shape, width, or other deformity of the nail plate.

I understand that mild adverse reactions with normal treatment protocols may occur and include the following: feeling of warmth and/or slight or mild pain (only during treatment); redness of the treated skin around the nail (lasting 24-72 hours); discoloration or burn marks on the nail; slight swelling of the treated skin around the nail (lasting 24-72 hours); and in rare cases, blistering and scarring of the treated skin around the nail.

I understand that post-treatment care is an important part of the treatment, and I agree to follow all post-treatment recommendations to ensure best results.

EYE SAFETY: I understand that Class IV lasers emit both visible and invisible radiation. Protective eyewear is necessary at all times during the treatment. I will not remove the Safety Goggles until the administrator of the laser has turned off the laser treatment and provided notification that it is safe to remove them. I will remove all reflective objects, such as rings, metal watchbands, and jewelry prior to treatment with the laser, to avoid reflective surfaces. I will never look directly into the end of the laser therapy hand piece.

ACKNOWLEDGEMENT: I certify that I have read or have had read to me the contents of this form. I have had the opportunity to ask questions, and all of my questions have been answered. I agree to the terms listed in this consent and agree to this treatment with the understanding that this Laser Treatment Consent Form applies to subsequent visits and treatments.

Patient Name ______________________________

Address ______________________________

City ______________________ State ____________ Zip ____________

Phone ______________________________

Email ______________________________

Patient Signature ______________________ Date ____________

FOR OFFICE USE ONLY BELOW THIS LINE

Physician Name ______________________________

Address ______________________________

City ______________________ State ____________ Zip ____________

Phone ______________________________