DOCTORS OF INTERNAL MEDICINE

PATIENT CONSENT FORM
FOR TREATMENT OF WARTS & NAIL FUNGUS

I hereby authorize Dr._____ or _____, under Dr. _____'s supervision to treat my wart(s)/nail fungus using a laser device. I understand that multiple treatments may be required and it is possible the result will be minimal or may not help at all. I understand that this procedure works on eliminating fungus by creating a thermal response in the dermis and/or nail bed.

The procedure may result in the following adverse experiences or risks:

- DISCOMFORT – Some discomfort may be experienced during treatment.
- REDNESS/SWELLING/BRUISING – Short term redness (erythema) or swelling (edema) of the treated area is common and may occur. There also may be some bruising.
- SKIN COLOR CHANGES – During the healing process, there is a possibility that the treated area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- WOUNDS – Treatment can result in burning, blistering, or bleeding of the treated areas. If any of these occur, please call our office.
- INFECTION – Infection is a possibility whenever the skin surface is disrupted, though proper wound care should prevent this. If signs of infection develop, such as pain, heat or surrounding redness, please call our office __(Phone number)_____.
- SCARRING – Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.
- EYE EXPOSURE – Protective eyewear (shields) will be provided to you during the treatment. Failure to wear eye shields during the entire treatment may cause severe and permanent eye damage.

I acknowledge the following points have been discussed with me:

- Potential benefits of the treatment of warts, including the possibility that the procedure may not work for me.
- Alternative treatments such as topical or oral medications or even surgery
- Reasonably anticipated health consequences if the procedure is not performed
- Possible complications/risks involved with the proposed procedure and subsequent healing period

For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Futhermore, I agree to keep Dr._____and staff informed should I become pregnant during the course of treatment.

Photographic documentation will be taken. I hereby do___do not___authorize the use of my photographs for teaching purposes.

ACKNOWLEDGMENT

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FORM FOR TREATMENT OF WARTS, AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.

_____ _____ _____

Signature-Patient or Guardian Print Name/Relationship Date

_____ _____ _____

Signature-Witness Print Name Date

NAIL CARE

Post-Care Instructions

- Apply antifungal cream twice a day for two weeks
- May need to continue for a longer period if skin fungal infection continues
- Place antifungal powder in shoes once a week for 1-2 months.
- Wait 24 hours post treatment to apply nail polish
- Return to office in 3-4 months for follow up visit
- Feel free to contact us for any additional concerns. (972)758-4455