CONSENT FORM FOR DIOLAZE™ TREATMENT

I hereby request a DIOLAZE™ laser treatment by Kaado MD. I have read, understand, and agree to the following:

READ CAREFULLY AND INITIAL BEFORE PROCEEDING

DIOLAZE™ is an advanced laser hair removal procedure that safely and gently eliminates unwanted hair. The combination of efficacy, patient comfort and speed make DIOLAZE™ a leader in laser hair removal. It is powerful enough to target and treat even the most stubborn hair. No complete clearance of the area is guaranteed. As with all hair removal methods, DIOLAZE™ requires a series of treatments.

The treatment may require a local anesthetic (topical cream and/or injection) and/or oral sedation. This decision will be based on the treatment parameters and is at the physician's discretion.

It is recommended that you not take aspirin, allergy or cold medication, muscle relaxants, sleep medication, non-steroidal anti-inflammatory medication, or any blood anti-coagulants before this procedure. These medications may increase the risk of bruising. If you can stop these medications, you should do so one (1) week before the procedure.

I understand that DIOLAZE™ may be used in non-FDA approved areas, and I consent to the application of DIOLAZE™ in those non-FDA approved areas.

Therapy using DIOLAZE™ is contraindicated for those who are pregnant or nursing; have a pacemaker or internal defibrillator; have a permanent implant in the treated area such as metal plates and screws, silicone implants or an injected chemical substance; have current or history of cancer, especially skin cancer, or pre-malignant moles; have an impaired immune system due to immunosuppressive diseases such as AIDS and HIV, or use of immunosuppressive medications; have severe concurrent conditions such as cancer, cardiac disorders, seizure disorders, uncontrolled hypertension, and liver or kidney diseases; have a history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment area (prophylactic treatment may be given); have any active condition in the treatment area, such as sores, psoriasis, eczema and rash as well as excessively/freshly tanned skin; have a history of skin disorders such as keloid scarring, abnormal wound healing, as well as very dry, cracked, ulcerated, infected and fragile skin; have tattoos, permanent make-up in the treatment area, as they may be affected by the treatment; have any medical condition that might impair skin healing; have poorly controlled endocrine disorders, such as diabetes or thyroid dysfunction; or have had any surgical, invasive, ablative procedure in the treatment area in the last 3 months or before complete healing. **I certify that I am free of such conditions.**

POSSIBLE RISKS AND SIDE EFFECTS

I understand that possible side effects of the treatment include: local pain, skin redness (erythema), swelling (edema), damage to the natural skin texture (crust, blister, burn), change of pigmentation (hyper- or hypo-pigmentation), and scarring. Although these effects are rare and expected to be temporary, any adverse reaction should be reported immediately.

I recognize that during the procedure unforeseen conditions may necessitate different procedures than the above. I authorize the physician or assistant to perform such other procedures if they find them professionally desired.

I understand that facial outbreaks such as herpes simplex virus are possible with this treatment and that medication must be taken per doctor's instructions.

Protective eyewear must be worn during the treatment to protect your eyes from potentially blinding or permanently injurious laser exposure.

I understand the importance of the pre and post treatment instructions and that the failure to comply with these instructions may increase the possibility of complications.

I have discussed the nature of my condition, the recommended medical procedure, the general nature of the proposed treatment, reasonable therapeutic alternatives to the treatment, and the risks of such alternatives. My physician has discussed the common problems or risks. **I am advised good results are expected**, but the possibility and nature of complications cannot be accurately anticipated and therefore, **no guarantee has been expressed or implied** as to the success or other result of treatment. I have had the opportunity to ask questions, which have been answered to my satisfaction. I understand the procedure and its side effects.

BEFORE AND AFTER TREATMENT

Before and after treatment instructions have been discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction.

PHOTOGRAPHS

I give permission for photographs to be taken of all sites treated, which will be used to document my medical record. I also give permission for the photographs taken to be used for illustrations of scientific papers or use in educational/training lectures and select marketing materials. I understand my name shall not be used in any publication.

MEDICAL HISTORY

I have informed the doctor of all my known allergies and all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, antiplatelet or anticoagulation medications. I have been advised about which of these medications I should avoid taking on the days surrounding the procedure.

I understand Fouad Georges Kaado Moawad, M.D., or another trained staff member under Dr. Kaado's supervision, will provide my treatment. The treatment provider will rely on my documented medical history, as well as other information obtained from me in determining whether to perform this procedure. I have provided and agree to continue to provide accurate and complete information about my medical history and conditions. I herein state that I am not pregnant or nursing.

FOLLOW-UP TREATMENT

I agree to follow up with Kaado MD at the recommended intervals at the Kaado MD office location and to contact Kaado MD and advise of any change in my condition, medical history or any problem I may experience. I agree to contact Kaado MD immediately should any unusual side effects occur. I understand that in case of a medical emergency, I should call 911 or go to an emergency medical facility.

PAYMENT

I certify that I am aware of and accept the fees and charges for the treatment, and agree that I am solely responsible for payment to Kaado MD.

INFORMED CONSENT

By signing this **INFORMED CONSENT,** I hereby acknowledge:

1. I have read or had this Consent Form read and/or explained to me.
2. I fully understand and agree to the contents of this Consent Form.
3. I have been given ample opportunity to ask questions regarding this treatment and all questions have been answered to my satisfaction.
4. I understand that there are inherent risks, side effects and potential complications of this treatment, as described in this consent form.
5. No guarantees have been made concerning the results nor the outcome of this procedure.
6. This document constitutes the full disclosure and supersedes any previous verbal or written disclosures, or any advertising or marketing materials prepared by Kaado MD or others.
7. It is understood that Kaado MD only provides specialty services and is not responsible for my comprehensive medical care.

I hereby voluntarily request and give my consent for Kaado MD to perform the procedure described herein, the DIOLAZE™ Treatment as requested. My consent includes all follow up or repeated treatments as recommended by Kaado MD.

THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.

Client Name (Printed): _____

Client Signature: _____ Date: _____