CONSENT FOR CANDELA VASCULAR LESION THERAPY

PATIENT NAME:_____ SURGERY DATE: _____

PHYSICIAN: JARED C. STORCK, DO, FACOS

Dr. Storck has explained that the lesion the above-named patient has is called a:

_____

PROCEDURE:_____

The treatment chosen is the Candela Vascular Lesion Laser. The doctor has explained the theory of the Candela Vascular Lesion Laser, any risks involved, complications, its successes and benefits.

Alternate treatment methods, such as excision and grafting, injecting or sclerosing solutions, cauterization, irradiation and other laser therapies have been discussed.

Treatments with the Candela Vascular Lesion Laser will vary depending on the lesion size, location and color, as well as the age of the patient. The doctor has also explained treatment protocols, laser safety, and any precautions necessary.

I understand that some form of anesthesia may be necessary. I have been given the opportunity to ask questions and have received satisfactory answers.

I hereby authorize Dr. Storck and his delegated associates to perform and assist in the Candela Vascular Lesion Laser procedure. I authorize the taking and publicizing of any photographs in the course of the laser procedure for the purpose of medical education or treatment. I certify that I have read and fully understand the contents of this consent form before signing my name below.

SIGNED:_____ DATE:_____
(Patient or person legally authorized to consent for patient)

WITNESS:_____ DATE:_____
(To patient's signature)