Midnight Sun Family Medicine, P.C
Aesthetics Division
Non-Ablative Laser Genesis
Patient Consent

I understand that erythema is a common immediate reaction from the non-ablative rejuvenation laser treatment process. This typically resolves within 2 hours, but can last longer. I may also feel a gentle warming sensation of the skin during treatment. This a temporary condition and I understand that each person's discomfort level may vary.

_________ (Patient Initial) _________ (Dr/Tech Initial)

I understand that 4-6 treatments are required for the non-ablative laser facial procedure to be most effective. I understand that it is important to follow the recommended maintenance schedule for future treatments to keep the best possible results. I also realize that each individual's treatment response may be different; therefore, the number of treatments may vary to achieve desired results.

_________ (Patient Initial) _________ (Dr/Tech Initial)

I understand and agree the Dr. Hornberger may choose to take photos of my treatment area for the purpose of monitoring my progress.

_________ (Patient Initial) _________ (Dr/Tech Initial)

I understand that there is a 24-hour cancellation policy, and a $75.00 minimum fee or half the treatment cost will be charged, which ever is greater, if I fail to show or do not cancel at least 24 hours prior to a scheduled appointment.

_________ (Patient Initial) _________ (Dr/Tech Initial)

I also understand that once I have started my treatment program that there are no refunds.

_________ (Patient Initial) _________ (Dr/Tech Initial)

Patients with open wounds, malignant skin tumors and certain diseases, tattoos, or currently taking Accutane **cannot** be treated.

_________ (Patient Initial) _________ (Dr/Tech Initial)

Dr. Hornberger or a representative of Dr. Hornberger has explained the nature and purpose of the non-ablative laser facial treatment, including risks and possible complications, and has discussed the contents of this form with me. I have read and understand this consent form and I agree to its terms and authorize treatment. I further understand that Dr. Hornberger cannot guarantee the results and I will not hold Dr. Hornberger or her employees responsible for my individual results of the Non-Ablative Laser Genesis treatment that I have requested.

_________ (Patient Initial) _________ (Dr/Tech Initial)

Signature Patient or Guardian	PRINT Name/Relationship	Date
Signature-Witness MSFM	Print Name	Date