GLOW MEDSPA

Informed Consent for Nail Fungus Removal

Glow Medspa uses the Revolution laser, which is cleared by the FDA for the increase in clear nails in patients with onychomycosis (nail fungus). The Nd:YAG 1064 nm and 755 nm 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, including the following:

I understand that the clinical results may vary in different patients. In some patients, a touch-up or repeat session with the laser may be necessary.

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 Revolution 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 exposure of my eyes to light could harm my vision. I must keep the eye protection goggles on at all times.

I understand some of the potential side effects may include: feeling of warmth and/or slight or mild pain (only during treatment), redness of the treated skin around the nail (lasting 24 to 72 hours), discoloration or burn marks may occur on the nail, slight swelling of the treated skin around the nail (lasting 24 to 72 hours), the laser can create 'sparks' on the surface of the nail – this does not cause any problems, in rare cases, blistering of the treated skin around the nail and scarring of the treated skin around the nail may occur.

I understand that photographs may be taken before and/or after my procedure and at follow-up visits. I further understand that these photographs and patient data may be used for medical documentation, research, or publication. Private health information, such as patient's name and date of birth will be removed to protect patient privacy.

I understand that post-treatment care is a very important part of the treatment, and I agree to follow all post-treatment recommendations to ensure best results. 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 of this agreement/consent.

_____	_____	_____
Patient Name (Printed)	Patient Signature	Date
_____	_____	_____
Parent/Guardian Name (Printed)	Parent/Guardian Signature	Date