Elevate
Podiatry + Spa

PATIENT INFORMED CONSENT FORM
Laser Nail Treatment for Onychomycosis

I hereby authorize Dr. Choe or _____, under Dr. Choe's supervision to treat my nails with onychomycosis, or nail fungus. I understand that multiple treatments may be required and it is possible the result will be minimal or may not help at all.

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

MILD DISCOMFORT – A slight and uncomfortable warming sensation 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 of the treated area.

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.

NAIL COLOR CHANGES – Nails may darken after treatment.

BURNS and INFECTION – Treatment can result in burning and blistering of the treated areas, and subsequent infection. If signs of infection develop, such as pain or redness at the treated site, immediately call our office at 415-890-3377.

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 nail fungus, 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. Furthermore, I agree to keep Dr. Choe 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 THE TREATMENT OF MY NAILS WITH ONYCHOMYCOSIS, 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**