*NAME:*_____. *Date:*_____

Please read and initial each statement. Complete, underline or circle individual selection accordingly.

- I authorize Dr. Amelia Cheatham to perform IPL™ treatments on me in an effort to improve Dry Eye Disease due to Meibomian Gland Dysfunction / Dyschromia / Hyperpigmentation / Hair Reduction / PWS / Haemangioma / Angioma / Rosacea / Telangiectasia / Other _____
- I understand that there is a rare possibility of side effects or serious complications including permanent discoloration and scarring. I am aware that careful adherence to all advised instructions will help reduce this possibility _____
- I understand the below list of short-term effects and agree to follow matching guidelines:
    - Flaking of pigmented lesions – crusts may take 5 to 10 days to disappear and it is important not to manipulate or pick which may otherwise lead to scarring _____
    - Discomfort – during the procedure, I might experience a sensation similar to a rubber band snap which degree will vary per my skin condition and area sensitivity but that does not last long. A mild "sun-burn" sensation may follow for typically up to one hour and will be reduced with application of cooling and soothing creams _____
    - Reddening and swelling – severity and duration depend on the intensity of the treatment and the sensitivity of the area to be treated. These phenomena may be reduced with application of cooling and/or anti-inflammatory creams_____

- The procedure as well as potential benefits and risks have been thoroughly explained to me and I have had all my related questions answered _____
- I understand that sun exposure or tanning of any sort is not aligned with the pre and/or post-care instructions and may increase the chance for complications _____
- I understand that results may vary with each individual and acknowledge that it is impossible to predict how I will respond to the treatment and how many sessions will be required _____

• I consent to photographs being taken for the purpose of documenting my progress and response to the treatment and be kept solely in my medical record _____

• I consent to photographs being used for medical education or publication with applied discretion and not revealing my identity _____

For Dry Eye Disease due to Meibomian Gland Dysfunction and all other conditions (relevant for an upgraded configuration of the OptiLight device):

Skin type of the area to be treated: I□ II□ III□ IV□ V□ VI□			
	Ocular surgery or eyelid surgery, within 6 months prior to the first IPL session?	NO	YES
	Neuro-paralysis in the planned treatment area, within 6 months prior to the first IPL session ?	NO	YES
	History or active pre-cancerous lesions, skin cancer or pigmented lesions in the planned treatment area ?	NO	YES

Skin type of the area to be treated: I□ II□ III□ IV□ V□ VI□			
	Have you been diagnosed with Systemic Lupus Erythematosus?	NO	YES
	Presence or history of active cold sores, rashes or herpes simplex virus?	NO	YES
	Within 3 months prior to the first IPL session, use of photosensitive medication, including: Isotretinoin (Accutane), Tetracycline, Doxycycline, and St. John's Wort?	NO	YES
	Radiation therapy to the face or head within 12 months prior to the first IPL session or planned radiation therapy within 8 weeks after IPL session?	NO	YES
	Treatment with chemotherapeutic agent, within 8 weeks prior or after the first IPL session ?	NO	YES
	History of migraines, seizures or epilepsy ?	NO	YES
	Tattoos in the planned treatment area ? Any pigmented lesion on requested treatment area that should be protected?	NO	YES
	Exposure to sun or artificial tanning during 2 weeks prior to treatment ?	NO	YES
	Use of any products containing Retin-A, retinol, benzoyl peroxide, glycolic/salicyclic acids with the past few days prior to treatment?	NO	YES
	Pregnant or possibility of pregnancy, postpartum or nursing?	NO	YES
	HIV?	NO	YES
	Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis) or Melasma?	NO	YES

Skin type of the area to be treated: I□ II□ III□ IV□ V□ VI□			
	Any known allergy to medications? If so, list:	NO	YES
	List current over-the-counter and prescription medications taken:	NO	YES
	Botox within the week prior to IPL or planned within one week after treatment? Recent fillers or peels on treatment area?	NO	YES

My signature certifies that I duly read and understood the content of this informed consent form, and that I gave the accurate information as to my health condition. I hereby freely consent to OptiLight IPL treatments

_____ _____

Name of patient (please print) Name of Guardian (if patient if under 18)

_____ _____

Signature of patient/Guardian Date