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Dr. Gregory A. Greco

Plastic, Cosmetic & Reconstructive Surgery

CARING FOR YOUR LASERED SKIN

- After you leave the office you will notice that your skin will feel very hot for approximately 45 minutes. This sensation will stop. You should continue to ice your face every 15 minutes for several hours. Do not use ice if your skin becomes inflamed or blistered.
- Over-the -Counter-Motrin, Advil, Aleve, etc. may be used to control post laser inflammation.
- You will receive a Post-Laser Kit. Please use the kit according to the instructions. This will help recover and soothe your skin.
- You may apply additional moisturizers such as Aquaphor or Eucerin cream to your skin. ALL of these products, including the laser kit supplies will burn when applied for the first 24 hours. This is normal. Stop all applications if your skin becomes too inflamed. Keep your skin as moisturized as possible for the first 5 days after the procedure.
- You will be moderately red after the PIXEL laser for approximately 24 hours. Your skin may darken if the IPL laser was used. These areas will flake off. This will go away, however, you should plan on one full day of redness for your recovery. Everyone will react differently to the laser procedure. Some people may get very red and inflamed for several days after the procedure. This is not common but also is not unusual to see, especially in farer individuals
- You may shower the day of the procedure. You will notice that even water will make your skin slightly uncomfortable. Do not use harsh cleanser on your skin during this time. Use only the supplied cleanser for the first several days.
- You may exercise the day after your procedure, there are no restrictions but you must avoid direct sun exposure. This can significantly alter your result.
- Your skin will become extremely dry by approximately the third day and you will notice quite a bit of "micro" flaking. The exfoliation scrub will help alleviate the flaking. Continue to moisturize your skin.
- In approximately 6-9 days your skin will feel and look visibly improved and will continue to improve for several weeks.
- Please do not hesitate to call if you have any questions about the laser recovery process.

Signature _____ Date _____

www.drgregorygreco.com
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CERTIFIED-AMERICAN BOARD OF SURGERY

Alma Lasers™
Wellbeing Through Technology

Harmony Pixel Consent Form

Patient name _____

Treatment sites _____

I duly authorize DR. GRECO _____ **to use the Harmony Pixel 2940nm Er:Yag system to perform fractional ablative skin resurfacing and any post treatment medical requirements that may be necessary.**

I understand that the Harmony Pixel is a laser device designed for fractional ablative skin resurfacing and that clinical result may vary in different skin types. I understand there is a possibility of short-term effects such as reddening, blistering, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as scarring and permanent discoloration . These effects have been fully explained to me _____ (patient's initials)

Clinical results may vary depending on individual factors, including medical history, amount of sun damage or textural problems, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment.

I understand that treatment by the Harmony Pixel 2940nm Er:Yag system involves a series of treatments and the fee structure has been fully explained to me _____ (patient's initials)

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I am not pregnant at this time, and that I have not taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator. I also have completed a medical history checklist and been informed about what I must do and "not do" before, during and after the series of treatments.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Patient Signature_____

Date_____

Witness_____

Alma Lasers Inc. ▮ 485 Half Day Road ▮ Suite 100 ▮ Buffalo Grove, IL 60089 ▮ Tel: 224-377-2000 ▮ Fax: 224-377-2050
www.almalasers.com ▮ contact@almalasers.com

Informed Consent
Harmony Skin Rejuvenation

Patient Name: _____

Treatment Sites: _____ _____

I duly authorize DR. GRECO to perform the Harmony Skin Rejuvenation procedure and any other measures which in their opinion may be necessary.

I understand that the Harmony is a device used for skin rejuvenation and that clinical results may vary in different skin types. I understand there is a possibility of short-term effects such as reddening, blistering, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me _____ (patient's initials)

Clinical results may vary depending on individual factors, including medical history, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment.

I understand that treatment by the Harmony Skin Rejuvenation system involves a series of treatments and the fee structure has been fully explained to me _____ (patient's initials)

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I am not pregnant at this time, and that I have not taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Patient Signature: _____

Date: _____

Witness: _____

Informed Consent
Harmony Hair Removal

Patient Name: _____

Treatment Sites: _____

I duly authorize _____ to perform the Harmony Hair Removal procedure and any other measures which in their opinion may be necessary.

I understand that the Harmony is a device used for hair removal and that clinical results may vary in different skin types and hair types. I understand there is a possibility of short-term effects such as reddening, blistering, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me _____ (patient's initials)

Clinical results may vary depending on individual factors, including medical history, skin and hair type, patient compliance with pre/post treatment instructions, and individual response to treatment. I understand that epilation with the Harmony system is a safe alternative to methods used for removing unwanted hair, such as shaving, waxing, chemical epilation and electrolysis.

I understand that treatment by the Harmony hair removal system involves a series of treatments and the fee structure has been fully explained to me _____ (patient's initials)

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I am not pregnant at this time, and that I have not taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Patient Signature: _____

Date: _____

Witness: _____