



**SHIDELER  
DERMATOLOGY  
GROUP**

*Stephen J. Shideler, MD*

*Rebecca L. Bushong, MD*

*Kimberly S. Berebitsky, MD*

# IMPORTANT

Prior to your Fraxel Laser Treatment, PLEASE:

- ✓ Read the attached Instructions
- ✓ Sign the Fraxel Consent Form
- ✓ Read and Sign the Fraxel Financial Policy Form
- ✓ Sign the Photo Consent Form
- ✓ Return **ALL** signed forms to Shideler Dermatology **BEFORE** your treatment

## Thank You

755 West Carmel Drive, Suite 101  
Carmel, Indiana 46032  
317.846.2396 or 1.877.294.3100  
Fax: 317.846.1699  
E-mail: [info@shideler.com](mailto:info@shideler.com)  
[www.shideler.com](http://www.shideler.com)

**General, Cosmetic and Surgical Dermatology**  
*Botox<sup>®</sup>, Thermage<sup>®</sup>, Fraxel<sup>®</sup>, Laser Hair Removal, Sclerotherapy,  
Laser Vein Removal, Photorejuvenation, Laser Skin Resurfacing,  
Acne Laser Therapy, Hair Transplants, Liposuction,  
Therapeutic Facial Treatments and Aesthetic Procedures*



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***FRAXEL LASER-INSTRUCTION***

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***PREOPERATIVE INSTRUCTIONS:***

Please remove make-up and contacts before arrival to office. Shave hair, if applicable.

Please ***discontinue*** the following products/medication/supplements:

- ***TWO (2) WEEKS prior:*** Aspirin containing products.
- ***ONE (1) WEEK prior:*** Vitamin E & C supplements: Retin A & Topical Cortico Steriods.
- ***THREE (3) DAYS prior:*** All NSAIDS such as Aleve, Motrin, Advil, Ibuprofen and any other prescription anti-inflammatory medications. **Do not stop taking** any of the above without checking with the prescribing physician first.

If you are not sure if a medication that you are taking contains aspirin or an NSAID, please ask the trained staff at Shideler Dermatology Group or ask your prescribing physician.

Please ***notify us*** if you are allergic to lidocaine, which is used to provide local anesthesia, ***or if you*** have diabetes or take prednisone or other medications to suppress the immune system.

***Please notify us BEFORE your first treatment if you have a history of cold sores.***

Photographs will be taken throughout course of treatment.

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***POSTOPERATIVE INSTRUCTIONS:***

Use a non-irritating moisturizer 2-3 times per day. Use SPF 30 Sunblock. Avoid Retin A, Renova, Avage, and Topical corticosteroids for 1-2 wks.

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***RISKS:***

I have been informed of the possible procedure risks & complications such as: Redness, swelling, hypo/hyperpigmentation, scarring, keloid formation, blistering, infection, bruising.

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*Revised on May 6, 2006*

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***FRAXEL LASER CONSENT***

I have been informed that I may have to have multiple treatments before maximal results are achieved. I am aware there will be a low amount of discomfort during the procedure.

***I have been informed that if I have a history of cold sores, I must inform Shideler Dermatology BEFORE my first treatment.***

I have been informed of the possible procedure risks and complications such as: Redness, swelling, hypo/hyperpigmentation, scarring, keloid formation, blistering, infection, bruising.

I have received the preoperative instructions to follow before the procedure.

I have read and fully understand the instructions and risks and authorize the trained staff at Shideler Dermatology Group to perform the Fraxel Laser procedure on me.

***I have received a copy of the Preoperative Instructions and the Postoperative Instructions.***

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name (Printed) \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date: \_\_\_\_\_



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***FRAXEL FINANCIAL POLICY***

Patient Name: \_\_\_\_\_

Price Quoted: \_\_\_\_\_

To help you understand our financial policy, we have outlined some important factors below.

***DEPOSIT***

Immediately upon scheduling your procedure, we require a deposit amount that is equal to the price of your first treatment. This deposit is applied to your total procedure cost. The date and time of your procedure is subject to change until your deposit is received.

***CANCELLING AND RESCHEDULING FRAXEL***

If you need to cancel your procedure, we must receive notice of the cancellation ***no less than three (3) business days*** before the scheduled date. If we receive your cancellation within three (3) business days of the scheduled time, you will lose \$300 of your deposit. If we do not receive any notice at all, your total deposit will not be refunded. ***IT IS VERY IMPORTANT WHEN CANCELLING OR RESCHEDULING THAT YOU SPEAK DIRECTLY TO KAREN or DENNAE.*** If you reschedule your procedure within 90 days from the date of cancellation, your deposit will be re-applied to your new surgery date.

***PAYMENT***

For your convenience, we accept cash, Visa, MasterCard, Discover, cashier checks, money orders and personal checks. ***Your balance, minus your deposit, is due TWO WEEKS prior to your scheduled appointment.***

Type of card: Visa, MasterCard (circle one) AMOUNT TO BE APPLIED \$ \_\_\_\_\_

Account# \_\_\_\_\_ Exp Date: \_\_\_\_\_

If paying by personal check, please make check payable to: Shideler Dermatology Group.

***Your signature below indicated that you understand this policy and agree to its terms and conditions.***

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Staff Member \_\_\_\_\_ Date \_\_\_\_\_

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**PHOTO CONSENT**

*Please choose ONE of the following:*

I, \_\_\_\_\_ agree to have photograph(s) taken for my medical chart. I understand these photo(s) will **ONLY** be used for pre-operative and post-operative comparisons.

**I DO NOT AGREE** to have my photograph(s) used for patient teaching or patient counseling.

**I DO NOT AGREE** to the use of my photograph(s) for advertising or marketing purchases.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

=====  
I, \_\_\_\_\_ agree to have my photograph(s) taken for my medical chart. I understand these photo/or photos will be used for pre-operative and post-operative comparisons.

My signature below represents my approval to have my photograph(s) for patient teaching and patient counseling and that my photo(s) may be put in his archive photo album of patients.

**I DO NOT AGREE** to the use of my photograph(s) for advertising or marketing purchases.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

=====  
I, \_\_\_\_\_ agree to have my photograph(s) taken for my medical chart. I understand these photo/or photos will be used for pre-operative and post-operative comparisons.

My signature below **REPRESENTS MY APPROVAL** to have my photograph(s) for patient teaching and patient counseling and that my photo(s) may be put in his archive photo album of patients.

My signature below **REPRESENTS MY APPROVAL** for Shideler Dermatology Group to use my photograph(s) for advertising and marketing purposes. I understand that my face may or may not be in the photograph and that I will NOT be paid a fee for the use of my photograph(s).

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

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