

ELEVATED IMAGE

Advanced Medical Aesthetics & Primary Care • Joshua Le, DO

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INFORMED CONSENT FOR LASER TATTOO REMOVAL

Q-Switched / Picosecond Laser Tattoo Removal

Patient name		Date of birth	
Date of treatment		Provider	Joshua Le, DO

Treatment area(s): _____

Tattoo location / colors: _____ Approx. age of tattoo: _____ Professional ☐ Amateur ☐

Cosmetic/PMU ☐

1. How Laser Tattoo Removal Works

A laser delivers rapid pulses of light that are absorbed by tattoo ink, breaking it into tiny particles your body gradually clears over the following weeks. Multiple sessions spaced several weeks apart are required. Darker inks (black/blue) respond best; some colors (green, yellow, light blue, purple) and cosmetic/flesh-tone inks respond poorly or unpredictably. Complete removal cannot be guaranteed, and a faint "ghost" or residual ink may remain.

2. Sessions & Expected Results

- Multiple sessions:** Typically 6–12+ treatments spaced ~6–8 weeks apart; the number varies by ink, depth, color, location, and skin type.
- Gradual fading:** Ink lightens progressively; results are not immediate and complete clearance is not guaranteed.

3. Alternatives

Alternatives include: no treatment; surgical excision; dermabrasion; camouflage/cover-up tattooing. Each has its own risks, results, and cost.

4. Medical History & Contraindication Screening

Are you pregnant or breastfeeding?	Yes ☐ No ☐
History of cold sores / herpes simplex (HSV) if treating near the lips?	Yes ☐ No ☐
History of keloid or hypertrophic (raised) scarring?	Yes ☐ No ☐
Recent sun exposure, tanning, or self-tanner (within 2–4 weeks)?	Yes ☐ No ☐
Isotretinoin (Accutane) use within the past 6–12 months?	Yes ☐ No ☐
Photosensitizing medication, or history of photosensitivity?	Yes ☐ No ☐
History of hyperpigmentation or post-inflammatory pigment change?	Yes ☐ No ☐
Known allergy or prior reaction to tattoo ink (especially red)?	Yes ☐ No ☐
Active infection, rash, or open skin at the tattoo site?	Yes ☐ No ☐
Immunosuppression, or a light-triggered seizure disorder?	Yes ☐ No ☐

Other medications, supplements, allergies, or conditions: _____

5. Risks and Potential Side Effects

- Pain, redness, swelling:** A snapping/burning sensation during treatment; redness and swelling after.
- Blistering, pinpoint bleeding, scabbing & crusting:** Expected as the skin heals; do not pick.
- Hyperpigmentation or hypopigmentation:** Temporary or, less commonly, prolonged/permanent color change; higher risk in darker skin (Fitzpatrick IV–VI).
- Scarring or textural change:** Uncommon; risk increases with picking, infection, or aggressive settings.
- Incomplete removal / ghost image:** Some ink may not clear; results are not guaranteed.
- Paradoxical ink darkening:** Cosmetic, flesh-tone, or white/red inks can turn darker and may become harder to remove.
- Allergic reaction:** Rare; releasing certain inks (especially red) can trigger a local or, rarely, systemic allergic reaction.
- Infection & HSV reactivation:** Uncommon; keep the area clean and take antivirals if prescribed.
- Eye injury:** Protective eyewear/shields are worn at all times during treatment.

6. Pre- & Post-Treatment Care

- Avoid sun/tanning before and after treatment; use broad-spectrum SPF on the healing area.
- Do NOT pick, scratch, or pop blisters/scabs — this causes scarring and infection.

- Keep the area clean and dry; apply any ointment as directed; avoid swimming, saunas, and heavy sweating until healed.
- Report spreading redness, pus, fever, or a severe reaction to the clinic promptly.

7. Photography, Financial & Acknowledgments

I consent to clinical photographs for my record and treatment planning (other use requires separate authorization). I understand this is an elective, self-pay procedure priced per session, that complete removal is NOT guaranteed, and that multiple sessions at additional cost are typically required. My screening information is true and complete. I may withdraw consent at any time.

8. Consent to Treat

I have read and understand this consent, my questions have been answered to my satisfaction, and I consent to laser tattoo-removal treatment(s) by Joshua H. Le, DO, and/or designated staff.

_____	_____	_____
Patient signature	Print name	Date
_____	_____	_____
Provider signature (Joshua Le, DO)	Witness (if used)	Date

Office Use — Treatment Record

Date	Device / wavelength	Settings / fluence	Area / passes

TEMPLATE — verify against Washington State disclosure requirements and your malpractice carrier before clinical use.



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Dr. Joshua Le, DO