VIRGINIA
EAR NOSE & THROAT
The Choice is Clear

Informed Consent

BBL Forever Clear – Acne

I, _____, Authorize_____,

and/or a designated practitioner of _Dr. Alan Burke – Virginia ENT_ to perform _BBL forever clear_

on the following area(s) of my body: _____.

BBL (BroadBand Light) Forever Clear for the use in Acne Treatment utilizes light to destroy or minimize P. acnes bacteria, reduce inflammation, and minimize over-production of sebaceous oil glands. Multiple consecutive sessions will be needed to reduce acne and the severity of lesions. Approximately, a 40-80% reduction in the number of lesions and the prevention of new lesion formation is the expectation from the treatment course. Light from BBL is an intense burst of light and even though the special safety eyewear is in place, you will sense light emanating from the treatment area.

Common Side Effects & Risks

I understand there is a possibility of rare side effects such as scarring and permanent discoloration. Hyperpigmentation (browning) and hypopigmentation (lightening) usually resolve within 2-6 months. Safe precautions with sun exposure are recommended. In addition, possible short-term effects include redness, mild burning, edema (swelling), blistering and infection. Although rare, herpes simplex virus infections around the mouth can occur, with or without a known history of cold sores. Should any kind of infection occur, please contact your clinician immediately to prescribe appropriate medicine.

Photography

I do ____ or do NOT ____ consent to photographs and other audio-visual and graphic materials before, during, and after the course of my therapy be used for medical, marketing, and educational purposes. Although the materials will not contain my name or any other identifying information, I am aware I may or may not be identified by the photos.

☐ **I understand this involves payment, and the fee structures have been explained.**

☐ **I understand there are other options for treatment that are available, which have been explained.**

I have read and understood all information presented to me before signing this consent form. The staff gave me the opportunity to answer my questions to my satisfaction. I understand the procedure and accept the risks. I agree to the terms of this agreement.

Patient's Signature: _____ **Date** _____

Witness Signature: _____ **Date**: _____

DR. ALAN BURKE
Facial Plastic &
Reconstructive Surgery