I am requesting a Cryotherapy Treatment: A non-invasive treatment for the removal of benign skin lesions, and voluntarily by consent authorizes this procedure.

I understand that Cryotherapy Treatment utilizes extreme cold gas jet to freeze skin lesions. As a consequence, the water inside the cells freeze, expand and rupture the membrane of the cells. The cells that comprise the lesion are eliminated over time to allow new healthy tissue to grow in the same area. The repair process will actually extend over a two to three week period after treatment. I also understand that I may require a series of treatments to achieve the maximum cosmetic result. The procedure and complications have been explained to me and I have had the opportunity to have my questions answered.

I have been advised that the object of the procedure I have requested is improvement in appearance, not perfection. It is possible for imperfections to persist, and that the result might not live up to my expectations or goals.

I understand the possible complications of Cryotherapy Treatment to be as follows:

~ Pigmentation: both hypopigmentation & hyperpigmentation may occur, especially in patients with skin types 5-6, because melanocytes are more susceptible to sub-zero temperatures. Both generally last a few months, but can also be longer lasting.
~ Sensory impairment: though rare, damage to nerves is possible, particularly in areas where nerves are closer to the surface of the skin (e.g. fingers, wrists and behind the ears). This side effect usually disappears after several months.
~ Hair loss: like melanocytes, hair follicles are more susceptible to sub-zero temperatures. Hair follicles in the treated area are more likely to be destroyed, thus hair usually does not grow back in the area of the lesion after cryotherapy treatment.
~ Headaches: cryotherapy treatments around the face and scalp may cause some headaches which are most likely to fade a few hours after the treatment.
~ Blisters: temporary blisters may appear in the lesion area due accumulation of cellular fluids.

I understand the possible risks and side effects associated with Cryotherapy. I understand that infection is a rare possibility. I shall follow the prescribed post procedure skin care to avoid infection.

I understand that I need to refrain from exposing the area to any intensive sun light exposure and/or solarium. I shall use a sun block with a protection factor of 15 or higher for 20 days after the lesion disappeared. I understand that I may require additional treatments in order to achieve maximum results and that some imperfections are not amenable to Cryotherapy Treatment.

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