The Dermatology & Skin Cancer Center

Gregory J. Wilmoth, MD
Eric D. Challgren, MD
Margaret B. Boyse, MD
Tracey S. Cloninger, PA-C

Informed Consent Form For Levulan Photodynamic Treatment for Acne

Name of Patient: ______________________________________ **Chart #:**____________ **Date:** ____________________

Provider:____ **Time Required for Procedure:** _________________

Levulan (Aminolevulinic acid 20%) is a naturally-occurring photosensitizing compound which has been approved by the FDA to treat a type of pre-cancerous skin lesions called *actinic keratosis*. Levulan is applied to the skin and subsequently "activated" by specific wavelengths of light. This process of activating Levulan with light is called "Photodynamic Therapy". The purpose of activating the Levulan is to improve the appearance of, and reduce acne rosacea, acne vulgaris, sebaceous hyperplasia, decrease oiliness of the skin, and improve texture and smoothness by minimizing pore size. Any pre-cancerous skin lesions are also simultaneously treated. The improvement of these skin conditions (other than actinic keratosis) is considered "off-label" use of Levulan.

I understand the Levulan will be applied to my skin for 30-90 minutes. Subsequently, the area will be treated with a specific wavelength of light to activate the Levulan. Following my treatment, I must wash off any Levulan from my skin. I understand I should avoid direct sunlight for 24 hours following the treatment, due to increased photosensitivity.

Anticipated side effects of Levulan treatment include discomfort, swelling, burning and possible skin peeling, especially on sun damaged areas, and on pre-cancerous lesions, as well as lightening or darkening of skin tone and spots, and possible hair removal. The peeling may last many days, and the redness for several weeks, if I have an exuberant response to treatment.

I consent to the taking of photographs of my face before each treatment session, to evaluate effectiveness. These will not be shared with any other party, unless specifically approved in writing by me.

I understand that medicine is not an exact science and that no guarantees are offered regarding my expected results. I am aware that some individuals have excellent results, and that it is possible that this treatment will not work for me. I understand that alternative treatments include topical medications, oral medications, cryosurgery, excisional surgery, and doing nothing.

I have read the above information and understand it. My questions have been answered satisfactorily by the doctor and staff. I accept the risks and complications of the procedure. I believe I am not pregnant, and understand I should not have this procedure if I am pregnant. By signing this consent form, I agree to have one or more Levulan treatments.

I voluntarily request PDT treatment by Dr. _______________________________ which has been explained to me, and my questions regarding such treatment, its alternatives, its complications and risks have been answered by the doctor, staff, and/or via written information. The information which I have been given has been in terms clear to me and I understand the risks and complications of the treatments. My questions have been fully and completely answered for me and I have read this document and understand its contents. I hereby give my unrestricted informed consent for the procedure.

Patient Signature (or other authorized): _______________________________________ Date: ______________

Signature of Witness: ____ Date: ______________

I have informed the patient of the available alternative procedures, and of the potential risks and complications that may occur as a result of this treatment.

Dr. ____ Date: _________________________________

Treatment & Payment Plan

My treating physician expects that I will need _________ (#) treatments, at $ 300 per treatment, 3-4 weeks apart.

I understand that, since this is cosmetic and therefore not covered by insurance, payment is due as follows: a minimum of 50% ($150 per treatment) is due at the time of scheduling the procedure, and the remaining amount is due at the time of check-in on the day of the procedure. Should I fail to appear for my appointment, or reschedule my appointment at least 2 business days prior to the scheduled procedure, I understand my payment(s) are forfeited.

Patient Signature (or other authorized): _______________________________________ Date: ______________