



3919 W Jefferson Blvd, Suite B
Fort Wayne, IN 46804
Phone - (260)450-1313
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FAQS: Erbium Microlaser Peel (MLP)

Patient Name: _____ **DOB:** ___/___/___

Procedure(s): _____ **Date of Procedure:** ___/___/___

Total Cost Due:\$ _____

What is the procedure used for?

Microlaser peels provide the effects of a moderate to deep chemical peel but with a more controlled, even, and consistent result. Used to even out skin-tone and improve texture on the face, neck, chest, and back of the hands. It is often combined with intense-pulsed-light (IPL) for an improved overall result (also known as the "Arctic Peel")

What changes can I expect right after treatment?

White appearance of the skin right after treatment sometimes lasting several hours, followed by moderate to intense redness for 2-3 days, followed by tightness, darkening, and finally peeling of the skin over the course of about 1 week.

When will I be completely healed?

At 1 week most patients will have only mild scattered redness which can be covered with makeup. Social engagements are not recommended for at least 1 week after treatment.

How many treatments are recommended? How far apart?

2-3 treatments, spaced 1 month apart

How painful is treatment?

Pain 5/10. We recommend ibuprofen or Tylenol and application of topical numbing cream one hour before the procedure for comfort.

How long does the treatment last?

15-30 minutes depending.

When can I expect to see the full results?

Within 1 week



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_____ (Initials) Your signature at the bottom of this form signifies that you understand that the services and/or supplies identified above may not be considered eligible for benefits (i.e. service may be determined not to be medically necessary, non-covered or investigational) by your health insurance carrier.

_____ (Initials) You will be responsible for payment in full at the conclusion of the visit and fully accept the fact that the charges incurred are out-of-pocket expenses and will not be reimbursed by your insurance carrier. This office will at no time, now or in the future, submit a claim to your insurance carrier as the provider has deemed the service to be not medically necessary under the terms of this practice's contract with your carrier.

By signing below, I am acknowledging that I am financially responsible for payment of the full balance at the time of service.

Patients Signature: _____

Date Signed : ___/___/___