

PATIENT CONSENT FORM
FOR LASER HAIR REMOVAL

Patient /Client Name: _____

Attending Physician: _____

I hereby authorize and direct any associates of Dr. _____ to perform laser assisted hair removal on me. I understand that this procedure works on the growing hairs and not on dormant hairs. For this reason, complete destruction of all hair follicles from any one treatment is unlikely, and I understand that I will require several treatments to obtain a significant, long-term reduction of hair growth. I also understand some people may not experience complete hair loss even with multiple laser procedures.

The following points have been discussed with me:

- Potential benefits of the proposed procedure
- Possible alternative procedures
- Probability of success
- The reasonably anticipated consequences if the procedure is not performed
- The most likely possible complications/risks involved with the proposed procedure and subsequent healing period, including, but not limited to, infection, scarring, crusting, re-growth of hair and/or blistering.
- Post treatment instructions.

I am aware of the following possible experiences/risks with laser surgery:

- DISCOMFORT – Some discomfort may be experienced during laser treatment.
- WOUND HEALING – Laser surgery can result in swelling, blistering, crusting, or flaking of the treated areas, which may require one to three weeks to heal. Once the surface has healed, it may be pink or sensitive to the sun for an additional two to four weeks, or longer in some patients.
- BRUISING/SWELLING/INFECTION – With some lasers, bruising of the treated area may occur. Additionally, there may be some swelling noted. Finally, skin infection is a possibility, although rare, whenever a skin procedure is performed.

- PIGMENT CHANGES (Skin Color) – During the healing process there is a slight possibility that the treated area can become either hypo-pigmented (lighter), or hyper-pigmented (darker), in color compared to the surrounding skin. This is usually temporary, but on a rare occasion, it may be permanent.
- SCARRING – Scarring is a rare occurrence, but it is a possibility if the skin’s surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions carefully.
- EYE EXPOSURE – Protective eyewear (shields) will be provided. It is important to keep these shields on all times during the treatment in order to protect your eyes from accidental laser exposure.

ACKNOWLEDGMENT

I UNDERSTAND AND ACKNOWLEDGE THAT PAYMENTS FOR THE ABOVE PROCEDURE ARE NON-REFUNDABLE AND DUE ON THE DAY SERVICES ARE RENDERED. BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THE PERMISSION FORM FOR LASER HAIR REMOVAL TREATMENT AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.

Signature of Patient / Guardian

Print Name / Relationship

Date