SplendorX Hair Removal Consent

- I authorize _____ to perform Splendor X treatments on me in an effort to improve Hair Reduction / Pseudofolliculitis Barbae / Other:_____
- I understand that there is a rare possibility of side effects or serious complications including permanent discoloration and scarring. I am aware that careful adherence to all advised instructions will help reduce this possibility
- I understand the below list of short-term effects and agree to follow matching guidelines:
    - Discomfort – during the procedure and shortly after, I might experience an itching sensation which degree will vary per hair density, area sensitivity and treatment head used but that does not last long. A mild "sun-burn" sensation may follow for typically up to one hour and will be reduced with application of cooling and soothing creams
    - Perifollicular erythema/oedema – severity and duration of the rash depend on the intensity of the treatment and the sensitivity of the area to be treated. These phenomena may be reduced with application of cooling and/or inflammatory creams
    - Micro-crusting over some areas with very dense and coarse hair – may take 5 to 10 days to flake off and it is important not to manipulate or pick which may otherwise lead to scarring.
    - Bruising may rarely occur and may last several days
- I understand that sun exposure or tanning of any sort is not aligned with the pre and/or post-care instructions and may increase the chance for complications
- The procedure as well as potential benefits and risks have been thoroughly explained to me and I have had all my related questions answered
- Pre and post-care instructions have been discussed and are completely clear to me
- I understand that results may vary with each individual and acknowledge that it is impossible to predict how I will respond to the treatment and how many sessions will be required
- I consent to photographs being taken for the purpose of documenting my progress and response to the treatment and be kept solely in my medical record
- I consent to photographs being used for medical education or publication with applied discretion and not revealing my identity
- I agree to review the following laser pre-treatment compliance checklist along with my Physician and bring accurate and updated data, to the best of my knowledge

Natural or artificial sun exposure in the past 3-4 weeks pre-op or the following 3-4 weeks post-op plan	No	Yes
Use of self–tanners or tan enhancer caps within the past 3-4 weeks pre-op plan	No	Yes
Photosensitive herbal preparations (St John's Wort, Ginkgo Biloba, etc…) or aromatherapy (essential oils)	No	Yes
Diseases which may be stimulated by light at 805 nm, such as history of Systemic Lupus Erythematosus or Porphyria	No	Yes
Pregnant or possibility of pregnancy, postpartum or nursing	No	Yes
Inflammatory skin conditions (dermatitis, active acne, etc...)	No	Yes
Presence or history of active cold sores or herpes simplex virus?	No	Yes
HIV?	No	Yes
Active cancer (currently on chemotherapy or radiation)	No	Yes
Previous skin cancer?	No	Yes
Medical history of keloids	No	Yes
History of erythema ab igne	No	Yes
Intake of isotretinoin within the past 6 months	No	Yes
Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis)	No	Yes
Any known allergy? If yes:_____	No	Yes
Any tattoo and/or dysplastic nevi on requested treatment area that should be protected?	No	Yes
Intake of aspirin or anti-coagulants?	No	Yes
Easy bruising?	No	Yes
Hormonal or endocrine disorders (PCOS or uncontrolled diabetes?)	No	Yes
Previous hair removal procedures on requested treatment area (other IPL/laser, wax, electrolysis, etc…) Within the past 6 weeks?	No	Yes
Previous skin procedures on requested treatment area (Botox, fillers, peels, etc...)	No	Yes

Please Circle Yes or No for the following:

My signature certifies that I have duly read and understood the content of this informed consent form, and gave the accurate information as to my health condition. I hereby freely consent to Splendor X treatments.

Name of Patient (please print) Signature of Patient Date

Name of Witness (please print) Signature of Witness Date