PATIENT CONSENT FORM

FOR LASER HAIR REMOVAL

I herby authorize _____ to perform light based hair reduction on me. I understand that this procedure works on the growing hairs (anagen) and not on dormant hairs. I understand that I will require several treatments to obtain a significant, long-term reduction of hair growth. I understand that I may experience fewer, thinner, lighter, slower re-growth of hairs, temporary hair loss or permanent hair reduction. I understand that it is only effective on hair with color and does not treat while, blond, or red hair. I understand that genetics, hormones, medication and hair color may interfere with hair loss and that I may not respond at all.

The procedure may result in the following adverse experiences or risks:

- DISCOMFORT– Some discomfort may be experienced during treatment.
- REDNESS/SWELLING/BRUISING – Short term redness (erythema) is common and swelling (edema) of the treated area may occur. Additionally, there may be some bruising.
- PIGMENTED CHANGES (Skin Color) – During the healing process, there is a slight possibility that the treated area can become either lighter (hypo-pigmentation) or darker (hyper-pigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- WOUNDS – Treatment can result in burning, blistering or bleeding of the treated areas. If any of these occur, please call the office.
- INFECTION – Infection is a rare possibility whenever the skin surface is disrupted, though proper wound care should prevent this. If signs of an infection develop, such as pain, heat or surrounding redness, please call the office at (949)916-7166.
- SCARRING – Scarring is a rare occurrence, but it is possibility if the skin's surface is disrupted. To minimize the changes of scarring, it is IMPORTANT that you follow all post-treatment instructions carefully.
- PARADOXICAL HAIR GROWTH – Stimulation of terminal hair growth following photo-epilation. Can occur within or adjacent to treated area.
- EYE EXPOSURE – Protective eyewear (shields) will be provided. It is important to keep these shields on at all times during the treatment in order to protect your eyes from any injuries.

I acknowledge the following points have been discussed with me:

- Potential benefits for the proposed procedure, including the possibility that the procedure may not work for me.
- Alternative treatments such as electrolysis, waxing, plucking and depilatories.
- Reasonably anticipate health consequences if the procedure is not performed.
- Possible complications/risks involved with the proposed procedure and subsequent healing period.

For women of childbearing age. By signing below I indicate that I am not pregnant. Furthermore, I agree the staff informed should I become pregnant in the course of treatment.
Photographic documentations will be taken.

ACKNOWLEGMENT

BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTANT THE CONTENTS OF THIS PERMISSION FORM FOR TREATMENT FOR VASCULAR LESIONS AND THAT DISCLOSUTRS REFFERD TO HEREIN WERE MADE TO ME.

_____ _____ _____

Signature-Patient or Guardian **Print Name/Relationship** **Date**

_____	_____	_____
Signature-Witness	**Print Name**	**Date**