INFORMED CONSENT FORM
Laser Hair Removal

I understand that laser hair removal treatment is FDA cleared for permanent hair reduction only and is intended for epilation of hair and that clinical results may vary with different skin types, hair color, and treatment area. I understand that there is a possibility of rare side effects such as scarring and permanent discoloration as well as short-term effects such as reddening, irritated raised rash, blistering, mild burning, swelling, bruising, numbing or temporary discoloration of the skin. _____ (Patient initial) _____ (Dr/Tech initial).

I understand that if I have a tattoo or permanent make-up in the area to be treated, there is a possibility of blistering and lightening of the tattoo or permanent make-up. _____ (Patient initial) _____ (Dr/Tech initial).

I understand that if I've had sun exposure or used a tanning bed within a 2-day period with the 1064 nm YAG and 4 week prior, during and post treatment with the 755 nm Alexandrite I risk a possible pigment change or blistering. _____ (Patient initial) _____ (Dr/Tech initial).

I understand that this procedure works on the growing hair follicles, not dormant hair. For this reason, complete destruction of all hair follicles from any one treatment is unlikely, and I understand that I will require multiple treatments at a regular scheduled interval to obtain significant, long-term reduction of hair growth. response may be different. Each individual has between 500 and 1000 follicles per square cm, of which many could be dormant and there is no way of knowing if and when they may start growing. I realize that each individual's treatment response is different; therefore, laser treatment results may vary and could range in number of treatments to achieve desired results or may be minimal or not help at all. I also understand that it may take up to 4 weeks for the treated hair to fall out after each treatment. _____ (Patient initial) _____ (Dr/Tech initial).

I understand that there are other options for hair removal such as electrolysis, waxing & chemical preparations. I understand the difference between these options and laser treatment, and am choosing laser as a non-invasive treatment for my hair epilation._____(Patient initial) _____(Dr/Tech initial)

I understand and agree that Medical Laser Solutions may choose to take photos of my treatment area for the purpose of monitoring my progress. _____ (Patient initial) _____ (Dr/Tech initial).

I have received post treatment instructions. _____ (Patient initial) _____ (Dr/Tech initial)

I have read and agree to the financial policy established by Medical Laser Solutions._____(Patient initial)_____(Dr/Tech initial

Medical Laser Solutions or a representative of Medical Laser Solutions has explained the contents of this form with me and I understand the nature and purpose of the laser hair removal treatment, including its risks, possible complications, and the fact that each person's treatment response may be different. I have read and understand this consent form and I agree to its terms and authorize treatment. I further understand that Medical Laser Solutions cannot guarantee the results and I will not hold Medical Laser Solutions or their employees responsible for my individual results of the hair removal treatment that I have requested. _____ (Patient initial) _____ (Dr/Tech initial).

Print Patient Name: _____

Signature: _____ Date: _____
(Parent or Guardian if patient is under 18)
Witness: _____ Date: _____