HAIR REMOVAL DISCLOSURE & CONSENT FORM

I, _____ hereby duly authorize _____,
physician, healthcare professional, or surgeon in charge, together with specially trained technicians or such assistants as he/she may designate to perform the special hair removal procedures using *light-based therapy* methods. I understand that *light-based therapy* offers varying intensities of light depending upon the modality used in order to destroy the hair follicle. The pigment in the hair follicle will absorb the light from the modality used. I understand that this is a relatively new medical cosmetic procedure and that long-term studies are ongoing. Past studies indicate that this is an alternative method for removing unwanted hair and that the results from the treatment can vary with each individual (from patient to patient) according to their skin and hair type as well as the medical condition of the patient/client. I do understand that other forms of hair removal methods exist. However, the purpose of this selected *light-based therapy* treatment is to attempt to reduce or eliminate unwanted hairs and does not guarantee permanent hair removal in all cases and that a small possibility exists that the procedure will not cause permanent reduction in hair growth. I am aware that multiple consecutive treatments (every 2 to 4 weeks) may be necessary to achieve satisfactory results. They are repeated until the desired level of hair removal is observed. If hair is allowed to fully grow in after treatment, the subsequent treatment will be less effective. **Therefore, the following guidelines must be followed for effective results of hair removal procedures: 1)** The hair in the treatment area is SHAVED and not plucked or waxed. Plucked or waxed hair will render the treatment ineffective; **2)** Do NOT use any depilatory cream (it is NOT allowed during any course of treatment); **3)** I understand that I should follow the instructions for care after my hair removal treatment; **4)** I understand that sun exposure and not adhering to the post skin care instructions may increase my chance of complications.

I have been advised of the following possible risks and/or side effects of *light-based therapy* and further recommendations advised for the proper treatment of hair removal:

- The treatment may be painful, so to minimize this, the client may use a topical called Emla® or Ela-Max®.
- Mild discomfort, the crusting of the skin and Edema (minor swelling) may occur at the treated site immediately after treatment. Irritation and redness usually subsides in 72 hours or less after treatment.
- Color changes, such as Erythema (pink color), hyper pigmentation (darker than normal skin color; it may be brown/red discoloration) or hypo pigmentation (skin lightening) may occur in treated skin. This may take several months to return to normal.
- Skin must be protected from the sun for several weeks after treatment. Unprotected sun exposure 2 weeks prior to treatment and/or 2 weeks after treatment can possibly cause darkening or lightening side effects of the skin and/or may worsen a condition that has been hyper pigmented.
- If the client has used oral isotretinoin (Accutane) they must wait 6 months after this treatment ends before starting laser treatments.
- Blistering of the skin may occur. Scarring is a rare possibility but it has occurred in less than I % of the treatment population.
- Herpes simplex virus may become active and there may be an increased susceptibility to sunburn. It is recommended that Valtrex® be taken as prescribed to avoid an outbreak of herpes.
- Client and all personnel in treatment room must use proper eye protection; that which is deemed necessary by the manufacturer of the medical equipment being operated and is in accordance with OSHA regulations.

I certify that the nature, purpose of this treatment, risks involved, and the possibility of complications have been fully explained and are understood in the consent. The physician, nurse or technician has answered all of my questions. I agree to provide aftercare as directed by this treatment facility.

Signed: _____ **Date:** _____
(Patient/Client or Responsible Guardian)

Photographs: I hereby consent to have _____ photograph me and to use such photos for monitoring response to therapy, other documentation purposes and medical education.

Signed: _____ **Date:** _____
(Patient/Client or Responsible Guardian)

Witness: _____ **Date:** _____