Informed Consent for Hair Removal

Client's name: _____ Date: _____

Treatment Sites: _____

Previous hair removal methods _____ (shaving, tweezing, waxing, depilatories, electrolysis, laser)

The purpose of this procedure is to diminish or remove unwanted hair. The procedure requires more than one treatment and may produce permanent hair removal. The total number of treatments will vary between individuals. On occasion there are patients that do not respond to treatments. The treated hair should exfoliate or push out in approximately 2-3 weeks.

Alternative methods are waxing, shaving, electrolysis, and chemical epilation.

The following problems may occur with the hair removal system.

1. **There is a risk of scarring.**
2. **Short term effects may include reddening, mild burning, temporary bruising or blistering. Hyper-pigmentation** (browning) and **Hypo-pigmentation** (lightening) have also been noted after treatment. These conditions usually resolve within 3-6 months, but **permanent color change is a rare risk.** Avoiding sun exposure before and after the treatment reduces the risk of color change.
3. **Infection:** Although infection following treatment is unusual, bacterial, fungal and viral infections can occur. Herpes simplex virus infections around the mouth can occur following a treatment. This applies to both individuals with a past history of herpes simplex virus infections and individuals with no known history of herpes simplex virus infections in the mouth area. Should any type of skin infection occur, additional treatments or medical antibiotics may be necessary.
4. **Bleeding:** Pinpoint bleeding is rare but can occur following treatment procedures. Should bleeding occur, additional treatment may be necessary.
5. **Allergic Reactions:** In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations have been reported. Systemic reactions (which are more serious) may result from prescription medicines.
6. I understand that exposure of my eyes to light could harm my vision. I must keep the eye protection goggles on at all times.
7. Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, and hyper-pigmentation.

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic of concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I am not pregnant at this time, and I have not taken Accutane within the last six months. I do not have a pacemaker or internal defibrillator

ACKNOWLEDGMENT:

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release _____ (individual) and _____ (facility) and _____ (doctor) from all liabilities associated with the above indicated procedure.

Client/Guardian Signature _____ Date _____

Laser Technician Signature _____ Date _____