Laser Hair Reduction/Removal Consent Form

I _____(Patient Name) hereby authorize _____ (Medical Provider or Laser Technician) to perform laser hair removal treatments. The medical provider and/or laser technician obtained my medical history and found me eligible for treatment.

TREATMENT: The Diode Laser targets pigment in the hair follicle to treat unwanted pigmented hair for long-term hair reduction. Hair grows in 3 cycles: Anagen, Catagen, andTelogen phases. The laser works during the anagen or "growing phase" of hair growth. Therefore, multiple treatments are needed at regular spaced intervals (4-8 weeks) to treat all of the hair in a treatment area for significant reduction of hair growth. For maximum results, it is necessary to follow the recommended treatment schedule and pre/post care instructions.

CONTRAINDICATIONS

The use of lasers Elite+/Apogee+ by CynoSure is not recommended for individuals that have any of the following:

- Are hypersensitive to light in the near infrared wavelength region
- Have sun-damaged skin (treatment contraindicated with Alex laser only)
- Have recent sun exposure or use of tanning beds/tanning products such as creams, lotions and sprays
- Take medication which is known to increase sensitivity to sunlight
- Have seizure disorders triggered by light
- Take anticoagulants
- Take or have taken oral isotretinoin, such as Accutane® , within the last six months
- Take medication that alters the wound-healing response
- Have a history of healing problems or history of keloid formation
- Have an active localized or systemic infection, or an open wound in area being treated
- Have a significant systemic illness or an illness localized in area being treated
- Have a history of skin cancer or suspicious lesions
- Have lupus disease
- Are receiving or have received gold therapy
- Are pregnant or have been pregnant recently

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MEDICAL HISTORY: Laser therapy is not recommended if any of the following conditions exist. Please check any current medical conditions listed below that applied to you.

- ☐ Active acne, skin infection, herpes outbreak, or fever blisters
- ☐ Scars that turn white or brown
- ☐ Dark Spots after Pregnancy
- ☐ Psoriasis or Vitiligo
- ☐ Keloids (thick/abnormal scarring)
- ☐ Lupus / Auto-Immune Deficiency
- ☐ On antibiotics
- ☐ On transplant drugs
- ☐ On blood thinner rx
- ☐ Bleeding Abnormalities
- ☐ Leg Ulcer or Phlebitis
- ☐ Rheumatoid Arthritis
- ☐ Diabetes
- ☐ HIV
- ☐ Hepatitis
- ☐ Hirsutism
- ☐ Skin Cancer
- ☐ Surgical or metal implants
- ☐ Photosensitivity Disorder
- ☐ Epilepsy or Seizure Disorder that is triggered by light
- ☐ Sun exposure/tanning bed
    - within 4 weeks of treatment for the Alex laser
    - within 1 week of treatment for the Nd:YAG laser
- ☐ Botox or Filler within 2 weeks
- ☐ Chemical Peels within 2 weeks
- ☐ Microdermabrasion within 2 weeks
- ☐ Waxing/Plucking within the last 4 weeks
- ☐ Laser Resurfacing or Facelift within 8 weeks
- ☐ Accutane Treatment within 6 months
- ☐ Pregnant or Nursing
- ☐ None of these medical conditions

I have notified my treating clinician if I have one or more of the conditions above. _____**Initials**

I understand that treatment is NOT recommended for tanned patients until the tan has faded and that sun exposure must be avoided between treatments. I have not tanned, and will not tan, in the areas to be treated during the entire treatment course and for six weeks before and after treatment. This includes sun exposure and tanning booths. Artificial tanning products must be discontinued 2 weeks prior to treatments. _____**Initials**

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EXPECTATIONS: Multiple treatments are needed, weeks or months apart. Six (6) treatments are typical for Fitzpatrick Skin Types 1-3 and eight (8) treatments are typical for Fitzpatrick Skin Types 4-6, but some people may require more. Hair loss may be permanently reduced after several treatments, but not in all cases. Touch up treatment may be needed in the future. Results vary with the individual depending on skin color, hair color, and hair density. Loss of pigmented lesions such as freckles/moles may occur. Recurrence of hair growth may occur at the treated site. I also understand some people do not respond to treatments. _____**Initials**

PRE-POST CARE INSTRUCTIONS:

- Test spots may be done to evaluate skin response prior to start of treatment.
- A printed copy of these instructions has been given to me and I understand them completely.
- I accept responsibility in complying with the treatment care instructions provided.

POTENTIAL RISKS:

- DISCOMFORT - Mild discomfort may be experienced during laser treatments. The sensation of the laser is like a rubber band snapping against the skin, Anesthesia is usually not necessary as the laser uses a cooling device that delivers a spray to the surface of the skin with the laser pulse is delivered. Numbing cream (e.g. Lidocaine) is available to control discomfort if necessary.

- BLISTERING/ BRUISING/REDNESS/SWELLING - Short term effects may include reddening, swelling, and mild burning which typically lasts 1-3 days. Bruising, blistering, crusting or flaking may occur and require 1-3 weeks to heal.

- INFECTION - Skin infection is a possibility although rare, whenever a skin procedure is performed. Herpes simplex virus infections around the mouth can occur following a treatment. This applies to both individuals with and without a past history of herpes simplex virus infections. Antiviral medication is recommended and is available by prescription. Should any type of skin infection occur, additional treatments or medical antibiotics may be necessary.

- PIGMENT CHANGES - Hyperpigmentation (darkening) and Hypopigmentation (lightening) of the skin have been noted after treatment. These conditions usually resolve within 3-6 months, but permanent color change is a risk. Avoiding sun exposure before and after the treatment reduces the risk of color change. It is very important not to be tan (even minimally) when treated.

- SCARRING - However slight, there is a risk of scarring and skin textural changes. It is important that you follow all post treatment instructions carefully. Compliance is crucial for healing and prevention of scarring.

- BLEEDING - Protective eyewear will be provided. It is important to keep these goggles on that at all times during the treatment in order to protect your eyes from accidental laser exposure.

MEDICAL HISTORY: I have informed the medical provider of all my known allergies and all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies, antiplatelet or anticoagulation medications. I have been advised about which of these medications I should avoid taking on the days surrounding the procedure. I understand that the medical provider will rely on my documented medical history, as well as other information obtained from me in determining whether to perform this procedure. I have provided and agree to continue to provide accurate and complete information about my medical history and conditions. I am not pregnant/nursing and do not have any contraindication to this procedure.

FOLLOW-UP: I agree to follow up with the medical provider at the recommended intervals at the Carvery Health Clinic office location(s) and to contact the clinic if there is any change in my condition, medical history or any problem I may experience. I agree to call the office immediately and should any unusual side effects occur. I understand that in case of a medical emergency, I should call 911 or go to an emergency medical facility.

CONSENT FOR TREATMENT: The procedure has been explained to me and my questions regarding such treatment, its alternative, its complications, and its risk have been answered. The information provided is clear and I understand the risks/complications of the treatment. My questions have been fully answered and I have read this document to understand its contents. I understand that there are no guarantees, all sales are final and payment is due at time of treatment. I understand that I will continue to age and may need additional treatments/products in the future. I understand that aesthetic treatments are not going to take care of all my aging skin needs. I hereby give my unrestricted informed consent for treatment of designated aesthetic procedure/product. I also understand that this consent is valid for future treatments unless the policies of the office or the known risks for the procedure/product change. By signing this form I acknowledge that guarantees as to the final results of my treatment have not been made. THIS CONSENT FORM IS VALID UNTIL ALL OR PART IS REVOKED BY ME IN WRITING.

Initials: _____ I release the device manufacturer, medical provider/injector(s), and staff of Valley Health Clinic LLC and Revive Aesthetics LLC from any and all liability associated with any injuries and/or current or future conditions resulting from the skincare procedures or products.

Initials: _____ I authorize before, during and after the procedure(s) the taking of photographs to be part of my patient profile that may be used for educational, promotion or advertising purposes without disclosing my identity. I also release Valley Health Clinic LLC and its associated staff including Revive Aesthetics LLC from any liability in connection with the use of such photographs and/or videos. My name will not be used to identify these photographs without my written approval.

_____	_____	_____
Patient Name Printed	Patient Name Signed	Date
_____	_____	_____
Medical Provider Name Printed	Medical Provider Name Signed	Date

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