LASER HAIR REMOVAL INFORMED CONSENT

PATIENT CONSENT TO TREATMENT

1. I, _____, consent to and authorize staff members of Aesthetic Medicine to perform multiple treatments of laser-assisted hair removal on me. The areas to be treated include but are not limited to_____.
2. The nature and purpose of the treatment have been explained to me, and my questions have been answered to my satisfaction. I realize that darkening or lightening of the treated skin may occur, at times lasting many months following treatment. I also realize that other possible complications include superficial erosions, bruising, blistering, redness, swelling, and the rare possibility of permanent scarring.
3. I understand that topical anesthetics may be used if I so choose. I understand that I must wear the protective goggles at all times during actual treatment.
4. I understand that the treated area requires specific cleansing and care, and sunscreen or sunblock must be used 6 weeks after treatment. I agree to follow post procedure instructions to minimize the risk of problems.
5. I understand that the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume those risks. Alternative means of treatment and their risks and benefits have been explained to me, and I understand that I have the right to refuse the procedure. I am also aware that at least six to ten treatments may be necessary to achieve permanent hair reduction.
6. I certify that I have read this entire Informed Consent and that I understand and agree to the information provided in this form. I certify that I am a competent adult of at least 18 years of age. I understand that if I am a minor under the age of 18, the consent of my parent or legal guardian will also be required before treatment. This Informed Consent is freely and voluntarily executed and shall be binding upon my spouse, relative, legal representatives, heirs, administrators, successors, and assigns. I agree that any pictures taken of my treatment site may be used for publication or teaching purposes, however, my name will not be disclosed and complete confidentiality will be maintained.
7. I realize that no guarantee, warranty, or assurance has been made as to the treatment results.
8. I agree to adhere to all safety precautions and regulations during the laser treatment.
9. Refunds are not given on pre-paid packages. Credit can be applied to any other service or product.

Patient Name (Please Print) _____

Patient Signature _____Date_____

Witness Signature _____Date_____

Post procedure instructions given_____

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