

Consent for Laser Hair Removal

_____ I understand that the purpose of this procedure is to remove unwanted hair. The laser is generally not as effective on white, gray, blonde and red hair. The Light Sheer Laser is FDA approved and allows us to safely and effectively treat patients who are candidates for laser hair removal.

_____ I understand that the possible side effects of the procedure include pain, swelling, redness, /red discoloration or hypo-pigmentation (skin lightening), may occur in treated skin, also bruising, scarring, blistering and scabbing. Skin color changes, such as hyperpigmentation (brown discoloration), may take several months to resolve, if at all.

_____ I agree to inform my provider of all medications I am currently taking or will take in the future. I understand that even over-the-counter products and herbal medications can cause adverse reactions. I understand that not informing my provider of any changes increases my chances of developing burns, hives and prolonged redness. I also understand that certain medications, (hormones) can cause an increase in hair growth.

_____ I agree to inform my provider of the last time I had sun exposure and for what period of time. Sun exposure will increase the likelihood of burning and discoloration and goes against laser protocol.

_____ I understand that it is my responsibility to wear sunscreen and avoid getting a tan during the course of these treatments. I understand that sun exposure will increase the chances of developing a burn and other serious side effects.

_____ I agree to immediately inform my practitioner if I become pregnant.

_____ I understand that a single procedure will most likely fail to completely remove all unwanted hair in the treated area. Multiple treatments are required due to different hair growth cycles. Individual response will vary according to endocrine system, skin type, hair color, degree of tanning, follow up care, and the body area being treated.

_____ I agree to follow all written and verbal safety precautions during and after treatments. I agree to follow post treatment instructions.

Acknowledgement

The purpose of this treatment has been explained to me and I have had an opportunity to ask questions about the treatments. Any questions I have regarding this treatment have been answered to my satisfaction and I fully understand the contents of this consent form. I understand that there are no guarantees that this procedure will effectively remove or reduce hair. I understand that payments for the above procedure are non-refundable.

I hereby authorize and direct West Suburban Women's Health at Antares and members of its staff to perform laser hair removal on me.

Signature of Client _____ **Date** _____

Signature of Practitioner _____ **Date** _____