



LASER HAIR REMOVAL PATIENT CONSENT

I hereby authorize and direct Dr. Goncalves' laser technician to perform laser assisted hair removal on me. I understand that this procedure works on the growing hairs and not on dormant hairs. For this reason, complete destruction of all hair follicles from any one treatment is not possible and I understand that I will require several treatments to obtain a significant, long-term reduction of hair growth. I also understand that some people may not experience complete hair loss even with multiple laser treatments.

The following points have been discussed with me and I have had the opportunity to ask questions:

- ◆ The potential benefits of the proposed procedure
- ◆ The possible alternative to this procedure
- ◆ The probability of success
- ◆ The reasonably anticipated consequences if the procedure is not performed
- ◆ The most likely possible complications/risks involved with the proposed procedure and subsequent healing period, including, but not limited to infection, scarring, crusting, re-growth of hair, or blistering
- ◆ Pre-and post-treatment instructions.

I am aware of the following possible experiences/risks that can result:

DISCOMFORT: Some discomfort may be experienced during laser treatment.

BRUISING/SWELLING/INFECTION: Occasionally, bruising of the treated area may occur. Additionally, there may be some swelling, or rarely an infection of the skin at site of the treated area may occur.

SKIN PIGMENT CHANGES: During the healing process, there is a slight possibility that the treated area can become either lighter or darker in color compared to the surrounding skin. This is usually temporary but rarely may be permanent.

WOUND HEALING: Laser Hair Treatment can result in swelling, blistering, crusting or flaking of the treated areas, which may require 1-3 weeks to heal. Once the surface has healed, it may be pink or sensitive to the sun for several months or longer in some patients. This is more likely to happen in patients taking medications causing photosensitivity or in patients with dark skin.

SCARRING: Scarring is a rare occurrence, but it is a possibility when the skin's surface is disrupted. To minimize the risk of scarring, it is important to follow all post-treatment instructions carefully.

Patient Initials: _____



EYE EXPOSURE: Protective eyewear (colored shields) will be provided for wear during the laser treatment. It is **MANDATORY** that the shields be worn at all times during the treatment. Failure to do so could result in accidental laser exposure to the eye that could cause vision damage.

LACK OF PERMANENT RESULTS: No procedure can guarantee permanent hair removal. Treatments may vary among patients. For some this may mean a significant decrease in the frequency with which you must shave or tweeze. For others, it may mean permanent cosmetic improvement because hair re-growth is minimal., very fine or completely absent. **EVERYONE WILL EXPERIENCE SOME HAIR RE-GROWTH** over time, regardless of the technology used. Hair that grows back will tend to be finer, lighter and less dense.

ACKNOWLEDGEMENT

I understand and acknowledge that payments for the above-named procedure(s) are non-refundable. _____ Initial

By my signature below, I certify that I have read and fully understand the contents of this consent for Laser Hair Removal and that the disclosures referred to herein were made to me.

Client Signature

Date

Technician Signature

Date