# HAIR REMOVAL DISCLOSURE & CONSENT FORM

I, ________________________________ authorize _______________________________________ physician, healthcare professional, together with specially trained technicians or such assistants as he/she may designate to perform the special hair reduction procedures using light- based therapy methods.

I understand that light- based therapy offers varying intensities of light depending upon the modality used in order to destroy the hair follicle. The pigment in the hair follicle will absorb the light from the modality used.

I understand this is a medical cosmetic procedure and long- term studies are ongoing. Past studies indicate this is an alternative method for reducing/removing unwanted hair and the results from the treatment can vary with each individual (from patient to patient) according to their skin and hair type as well as the medical condition of the patient/client.

I understand other forms of hair reduction/removal methods exist. However, the purpose of this selected light- based therapy treatment is to attempt to reduce or eliminate unwanted hairs and does not guarantee permanent hair removal in all cases and a small possibility exists the procedure will not cause permanent reduction/removal in hair growth.

I am aware multiple consecutive treatments (every 2 to 4 weeks) may be necessary to achieve satisfactory results. They are repeated until the desired level of hair reduction is observed. If hair is allowed to fully grow in after treatment, the subsequent treatment will be less effective.

Therefore, the following guidelines must be followed for effective results of hair reduction procedures:

1. The hair in the treatment area is SHAVED and not plucked or waxed. Plucked or waxed hair will render the treatment ineffective.
2. Do NOT use any depilatory cream (it is NOT allowed during any course of treatment).
3. I understand I should follow the instructions for care after my hair removal treatment.
4. I understand sun exposure and not adhering to the post skin care instructions may increase

I have been advised of the following possible risks and/or side effects of light- based therapy and further recommendations advised for the proper treatment of hair reduction/ removal

- Mild discomfort, the crusting of the skin and Edema (minor swelling) may occur at the treated site immediately after treatment. Irritation and redness usually subsides in 72 hours or less after treatment.
- Color changes, such as Erythema (pink color), hyper pigmentation (darker than normal skin color; it may be brown/red discoloration) or hypo pigmentation (skin lightening) may occur in treated skin. This may take several months to return to normal.
- Skin must be protected from the sun for several weeks after treatment. Unprotected sun exposure 2 weeks prior to treatment and/or 2 weeks after treatment can possibly cause darkening or lightening side effects of the skin and/or may worsen a condition that has been hyper pigmented.
- If the client has used oral Accutane they must wait 6 months after this treatment ends before starting laser treatments.
- Blistering of the skin may occur. Scarring is a rare possibility but it has occurred in less than 1 % of the treatment population.
- Herpes simplex virus may become active and there may be an increased susceptibility to sunburn. It is recommended that Valtrex® be taken as prescribed to avoid an outbreak of herpes.
- Client and all personnel in treatment room must use proper eye protection; that which is deemed necessary by the manufacturer of the medical equipment being operated and is in accordance with OSHA regulations.

I certify the treatment, risks involved, and the possibility of complications have been fully explained and are understood in the consent. The physician, nurse or technician has answered all of my questions. I agree to provide aftercare as directed by this treatment facility.

Signed: ________________________________ Date: __________________________

(Patient/Client or Responsible Guardian)

Photographs: I hereby consent to have ________________________________ photograph me and to use such photos for monitoring response to therapy, other documentation purposes and medical education.

Signed: ________________________________ Date: __________________________

(Patient/Client or Responsible Guardian)

Witness: ____________________________________________

Date: _____________________________

## Pre-Procedure Care Instructions

- Avoid tanning in the areas to be treated. The more an area is tanned, the lower the fluence (energy) that can be used which may decrease the efficacy of treatment.
- Do not pluck, wax or have electrolysis performed 2-4 weeks before having laser hair removal. In order for laser hair removal to be most effective, the hair follicle must be present. Plucking and waxing remove the hair follicle and therefore decreases the melanin that serves as the target for the laser.
- Shave or very closely trim the area to be treated 1-2 days prior to laser hair removal is performed.
- Do not apply make-up to the area to be treated on the day of procedure.
- Anyone with a history of herpes (cold sores) or zoster (shingles) in the area to be treated should be taking preventative anti-viral medications starting 1-2 days prior to the procedure.

## Post-Procedure Care Instructions

- Avoid sun exposure or use sunscreen with an SPF of 30 or greater.
- Avoid trauma such as picking or scratching of the area.
- Make-up should not be applied until the next day. If any blistering or crusting has developed, make-up should be not be applied to that area until symptoms have resolved.
- Expect that shedding of hairs will occur, which may initially appear as though the hair is growing.
- Any preventative medications that were prescribed should be continued and finished.