COSMETIC LASER AND AESTHETICS CENTER

LIGHT SHEAR LASER HAIR REMOVAL INFORMATION AND CONSENT

I understand that the purpose of this procedure is to reduce and/or remove unwanted hair. There are several alternatives to laser hair removal treatment including but not limited to electrolysis, shaving, waxing, plucking, or no treatment at all.

I understand that the possible risks of the procedure include pain, bruising, swelling, redness, itching, skin inflammation or irritation (dermatitis), allergic reaction, ulcers, scarring, blistering, hypopigmentation, hyperpigmentation, mottling of skin vascularity and pigmentation, and other unforeseen complications, and that these can be temporary or permanent. I understand that a single procedure will most likely fail to remove all my unwanted hair in the area treated. Multiple treatments are required, although we may not be able to ever remove 100% of the hair. Individual response will vary according to skin types, hair color, degree of color/tanning, follow up care, and the body area being treated. Eye injury is possible but unlikely, providing complete eye protection is properly used throughout laser treatment sessions.

I understand the treatment may be painful, but this is typically manageable without any pain medication. Color changes, such as hyperpigmentation (brown/red discoloration) or hypopigmentation (skin lightening), may occur in treated skin and may be temporary or permanent. This may take several months to resolve, if at all. Unprotected sun exposure in the weeks following treatments is contraindicated as it may cause or worsen this condition. Blistering of the skin may occur. Temporary or permanent ulceration or scarring is uncommon but may occur.

I certify that I do not have any of the following conditions which are CONTRAINDICATIONS to laser hair removal: history of melanoma, raised moles, suspicious lesions, keloid scar formation, healing problems, active infections, open lesions, hives, herpetic lesions, cold sores, tattoos or permanent make-up in area of treatment, recent use of Accutane, tetracycline, or St. John's wort in the last year, autoimmune diseases such as Lupus, Scleroderma, Vitiligo. I certify that I am not pregnant, trying to get pregnant, or nursing. I have informed my physician of my recent sun exposure and if I have had any, I understand the risks of skin discoloration and other with treatment. I also understand that, while not a contraindication to treatment, the following drugs may cause increased hair growth: birth control pills, androgens (rogaine), penicillin, cyclosporins, minoxidil, steroids, haldol, phenytoin, thyroid medications.

I have not received any type of hair removal, except for simple shaving, in the last 6-10 weeks (depending on area treated) including plucking, tweezing, waxing, depilatories, electrolysis, or other laser hair removal, as this can decrease results. I also understand that if I have had any sun exposure in the last month or self tanning, this may increase the chance of hypo/hyperpigmentation and I have informed my physician of this, as the treatment may need to be postponed.

_____Initial that you have read and understand this page

I give permission for any pictures or videotape taken of me may be used for either teaching or publication, if considered appropriate_____(YES); _____(NO).

I give permission for my pictures to appear in Skin's photo album for other potential patients to view_____(YES); _____(NO).

I have been given the opportunity to ask questions about my condition and the treatment, alternative forms of treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I have sufficient information to give this informed consent. I certify that I have completely read the above form and the form has been fully explained to me, and I understand its contents. I understand that every effort will be made to provide a positive outcome, but that there are no guarantees.

I understand the procedure and risks (temporary and/or permanent), and accept the risks, and request that this procedure be performed on me by the doctor or other qualified staff.

I have been given pre- and post-procedure instructions and I understand them. If I have any questions, concerns, or signs of problems (extended redness, swelling, blistering, burns, ulcers, pain, signs of infection or other), I will immediately contact Skin and Dr. at the office or on Dr. 's cell phone

_____ _____
Name of the Patient (please print) Date

_____
Signature of the Patient

_____
Signature of Performing Nurse

_____ _____
Signature of Physician Date

_____Initial that you have read and understand this page

Laser Hair Removal Pre- & Post- Instructions

Pre-Care:

- The following conditions which are CONTRAINDICATIONS to laser hair removal: history of melanoma, raised moles, suspicious lesions, keloid scar formation, healing problems, active infections, open lesions, hives, herpetic lesions, cold sores, tattoos or permanent make-up in area of treatment, recent use of Accutane, tetracycline, or St. John's wort in the last year, autoimmune diseases such as Lupus, Scleroderma, Vitiligo, pregnancy, trying to get pregnant, or nursing.
- Do not pluck, wax, use a depilatory, or undergo electrolysis in the areas to be treated for at least 6 weeks. Shaving is okay. Please come in cleanly shaven in the area to be treated.
- Do not tan or use self tanner in areas to be treated for 4 weeks prior.
- Avoid any irritant chemical, soaps, lotions to area for the week prior.

Post-Care:

- Some redness and swelling is normal and may feel similar to a sun burn. This should resolve in a few days to a week. Some people may react more and have redness up to a month or longer. Notify your Skin and Dr. if it persists longer than a few days.
- During the next week, you may develop a fine crust/rug-burned appearance especially where many dark hairs were treated. Hairs will begin to shed (DO NOT PICK AT THEM). This may last for several weeks.
- Small blisters may occur. Keep area clean. Notify Dr. if this happens.
- Avene Cicalfate may be used
- You may apply cool compresses/ice for 15 minutes/hour for comfort.
- Gently clean the area twice daily with mild soap. Aloe gel can also be used.
- Avoid irritants (glycolics, acid, retinoids, etc.) until all redness/swelling resolves.
- Moisturizers may be used if they do not sting when applied.
- Apply medical grade sun block (with zinc oxide) for at least six weeks if not for your lifetime!
- Shaving should be avoided until comfortable. Begin with light shaving.
- Avoid strenuous exercise for the day as sweating may sting.
- Make-up may be used as long as skin is not broken or irritated.

Notify Dr. if you have any questions, concerns, problems.
I understand the above instructions. I understand the risks and signs of side effects and complications such as severe redness, swelling, blistering, burns, ulcers, pain, or signs of infection and I will call the office and Dr. immediately if I have any questions or concerns. **Initial**_____

Laser Hair Removal Pre-op Checklist

1. Takes an average of 6 treatments or more. Will see result (thinning and hair loss) with each treatment, so patient does not necessarily have to do 6 treatments if they just want thinning over a few treatments but complete hair loss usually takes 6 or more.

2. Patient cannot be recently sun-exposed or tan and cannot be going out in sun for at least a week or longer (depending on a few things) after the treatment.

3. Price is per area per treatment.

4. Patient needs to be clean shaven when they come in for their treatment.

5. Can't pluck or wax for one month before or during the treatment series. They CAN shave or cut hair with scissors.

6. Treatments are done 6-10 weeks apart depending on the area treated.

7. This IS permanent but a few hairs may come back over the next few years requiring a maintenance treatment. Will see more thinning at first with hair reduction as patient gets through the series.

8. All skin types/colors can be treated.

9. Patient will be required to purchase after treatment skin care (usually about $40) which will last for the series in most cases.

10. Only works on dark hairs, not peach fuzz, white/gray/blond hairs.

11. Expect mild irritation and possible folliculitis after treatment.

12. Discuss risks of burning and scarring, temporary or permanent, increased in darker skin, and that patient should notify Skin and Dr. immediately with any questions/concerns or any signs of extended redness, swelling, pain, infection, burn, ulcer or other.

These items have been discussed with the patient. The patient understands and has no questions and knows the warning signs of problem.

Patient _____ Date _____

Nurse _____

Dr. _____ Date _____

Laser Treatment Log for_____

Date_____ Treatment number_____ Beginning Pulse Count_____ End Pulse Count_____

I have had no changes in health, medication, or sun exposure since my last treatment _____ Client Initial
I have had the following changes in health, medication, or sun exposure
_____ _____Client Initial
I renew my original consent to treat form, knowing that all information is necessary for proper treatment _____Client Initial
Reactions to last treatment/length of time_____

Safety: Laser Sign/door goggles ☐ Eyewear on everyone in room ☐ Consent Signed ☐ Door Secured ☐
Treatment Area Joules/Pulse Duration Treatment Notes: Increase/Decrease in Tx Parameters /Reactions

Post-op Assessment: Perifollicular: Edema ☐ Erythema ☐ Evidence of Singed Hair ☐
Instructions: Standard Sheet ☐ Other:
Signature of treating Personel:

Date_____ Treatment number_____ Beginning Pulse Count_____ End Pulse Count_____

I have had no changes in health, medication, or sun exposure since my last treatment _____ Client Initial
I have had the following changes in health, medication, or sun exposure
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Instructions: Standard Sheet ☐ Other:
Signature of treating Personel:

Date_____ Treatment number_____ Beginning Pulse Count_____ End Pulse Count_____

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Safety: Laser Sign/door goggles ☐ Eyewear on everyone in room ☐ Consent Signed ☐ Door Secured ☐
Treatment Area Joules/Pulse Duration Treatment Notes: Increase/Decrease in Tx Parameters /Reactions

Post-op Assessment: Perifollicular: Edema ☐ Erythema ☐ Evidence of Singed Hair ☐
Instructions: Standard Sheet ☐ Other:
Signature of treating Personel:

Laser Hair Removal Treatment Record

Date _____ Patient name_____ Date of birth _____

Areas to be treated _____

Safety:

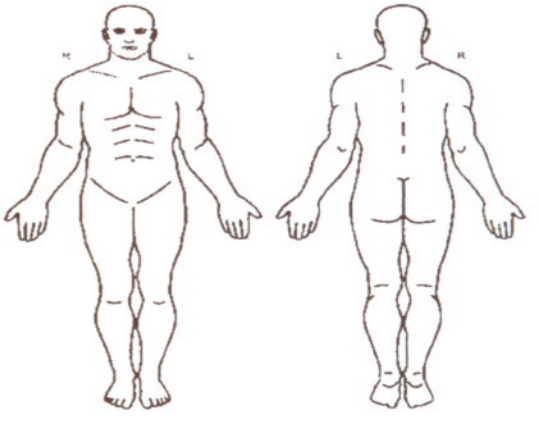
❑ Laser sign and laser appropriate goggles posted on door	❑ Door secured
❑ Goggles on everyone in room	❑ Consent Signed

Treatment number_____ Beginning Pulse Count_____ Ending Pulse Count_____

Test spots:

Skin type/ fluence (anticipated fluences, start 10J below for test spots, higher fluences possible with 100ms pulse duration)

❑ I	40+J	30 ms or Auto	❑ II	34-38J	30 ms or Auto
❑ III	30-35J	30 ms or Auto	❑ IV	25-30J	30 ms, Auto, or 100ms possible
❑ V	20-30J	30 ms 100ms	❑ VI	10-12J	30 ms or 100ms



Spot : Fluence/Duration

A_____ B_____ C_____ D_____ E_____ F_____

G_____ H_____ I_____ J_____ K_____ L_____

Treatment:

Anesthesia: ❑ None ❑ EMLA ❑ Other _____

Area	Fluence/Pulse duration	Treatment Notes

Post Op Assessment:

❑ Erythema: perifollicular, general ❑ Edema: perifollicular, general ❑ Singed hairs ❑ Blisters

Abnormal reactions _____

Instructions given to pt:

❑ Standard instruction sheet ❑ Other_____

_____

Signature of TreatingPersonnel_____