Informed Consent for Hair Removal

Customer's name: _____ Date: _____

Treatment sites: mono-brow, lip, chin, neck, face, arms, fingers, chest, areola, linea, underarms, back, buttocks, bikini, labia, scrotum, thighs, lower legs, feet and toes.

Combinations: _____

Previous hair removal methods _____(shaving, tweezing, waxing, depilatories, electrolysis, laser)

The purpose of this procedure is to diminish or remove unwanted hair. The procedure requires more than one treatment and may produce permanent hair removal. The total number of treatments will vary between individuals. On occasion there are patients that do not respond to treatments. The treated hair should exfoliate or push out in approximately 2-3 weeks.

Alternative methods are waxing, shaving, electrolysis and chemical epilation.

The following problems may occur with the hair removal system:

1. **There is a risk of scarring**.

2. **Short term effects may include reddening, mild burning, temporary bruising or blistering. Hyper-pigmentation** (browning) and **Hypo-pigmentation** (lightening) have also been noted after treatment. These conditions usually resolve within 3-6 months, but **permanent color change is a rare risk**. Avoiding sun exposure before and after treatment reduces the risk of color change.

3. **Infection:** Although infection following treatment is unusual, bacterial, fungal and viral infections can occur. Herpes simplex virus infections around the mouth can occur following treatment. This applies to both individuals with a past history of herpes simplex virus infections and individuals with no known history of herpes simplex virus infections in the mouth area. Should any type of skin infection occur, additional treatments or medical antibiotics may be necessary.

4. **Bleeding:** Pinpoint bleeding is rare but can occur following treatment procedures. Should bleeding occur, additional treatment may be necessary.

5. **Allergic Reactions:** In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations have been reported. Systemic reactions (which are more serious) may result from prescription medicines.

6. I understand that exposure of my eyes to light could harm my vision. I must keep the eye protection goggles on at all times.
7. Compliance with the aftercare guidelines is crucial for healing, prevention of scarring and hyper-pigmentation.
8. There is no guarantee that the expected or anticipated results will be achieved.
9. I have received a copy of the pre-treatment and post-treatment protocols and I understand that my compliance with these protocols is essential for healing prevention of scarring and hyper-pigmentation.

The list is not inclusive and additional side effects may occur, but I elect to proceed with the treatment. Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

ACKNOWLEDGEMENT:

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release Brandi Concolino and Two Spirit Health from all liabilities associated with the above indicated procedure.

Client/Guardian signature _____ Date: _____

Laser Technician Signature _____ Date: _____