

LASER HAIR REMOVAL

Laser hair removal systems emit a gentle beam of light that passes through the skin to the hair follicle. The hair absorbs it, the energy from the laser is transformed into heat, and the hair follicle is disabled. White skin with dark hair responds best as dark hair contains melanin, a dark pigment that attracts the laser light so more laser energy is absorbed. Light-colored hair is more difficult to treat requiring multiple sessions with varied results. Persons with dark skin or suntanned skin take longer to get results because melanin, the dark pigment in hair, is also present in skin. There is the danger of dark skin being burned in these instances, so a laser beam with a lower energy level is used.

The fluence range (energy level) of the laser beam can reach 100 J/cm². Use of fluences (energy levels) greater than 50 J/cm² is considered investigational by the FDA.

Patient's
Initials

- _____ The details of the procedure including the anticipated benefits and material risks have been explained to me in terms I understand.
- _____ I understand that multiple treatments will be necessary.
- _____ I understand that I will be wearing safety eye wear to protect my eyes from the laser light during the procedure.
- _____ Alternative methods and therapies, their benefits, material risks and disadvantages have been explained to me.
- _____ I understand and accept that the most likely material risks and complications of laser hair removal have been discussed with me and may include but are not limited to:
- *burn and/or blistering*
 - *localized redness and swelling*
 - *discomfort*
 - *permanent skin discoloration*
 - *dissatisfaction with results*
 - *scarring*
- _____ I am aware that if I smoke chances of complications could increase.
- _____ I have informed the doctor of all my known allergies.
- _____ I have informed the doctor of all medications I am currently taking, including prescriptions, over-the-counter remedies, herbal therapies and supplements, aspirin, and any other recreational drug or alcohol use.
- _____ I have been advised whether I should avoid taking any or all of these medications on the weeks surrounding the procedure.
- _____ I have been advised of other precautions I should take on the weeks surrounding the procedure, *i.e., avoiding the sun, avoiding plucking or waxing hair, etc.*
- _____ I am aware and accept that no guarantees about the results of the procedure have been made.
- _____ I have been advised of the probable consequences of declining recommended or alternative therapies.
- _____ The doctor has answered all of my questions regarding this procedure.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct _____, M.D., with associates or assistants of his or her choice, to perform laser hair removal on _____ at _____.

(patient name) (name of facility)

I further authorize the physician(s) and assistants to do any other procedure that in their judgment may be necessary or advisable should unforeseen circumstances arise during the procedure.

Patient or Legal Representative Signature/Date/Time

Relationship to Patient

Print Patient or Legal Representative Name

Witness Signature/Date/Time

Continued

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed procedure to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient fully understands what I have explained.

initial copy given to patient Physician Signature/Date/Time _____
initial original placed in chart

SAMPLE