Cosmetic and Obesity Solutions, LLC

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Laser Hair Removal Consent Form

I authorize _____ to perform LASER and/or Intense Pulsed Light (IPL) therapy for:Hair Reduction

Areas:_____

I understand that LASER and IPL therapy is performed with devices that produce transient, intense but gentle burst of light that fragments and removes the hair with selective destruction with minimum harm to the surrounding tissue. To protect my eyes from the intense light, I will have my eyes covered with an opaque material or wear laser protective glasses. I have been informed that for the best results multiple treatments are necessary.

I understand that immediately following treatment; the treated area may appear as a red discoloration (erythema) that may last up to 2-3 days, and may have slight edema (swelling), which may last up to two hours or longer. The treated area may feel like sunburn after treatment, and some darkening or peeling may be normal. These expectations, post treatment care and precautions have been explained to me. Improper care of the treated area may increase the chance of scarring or skin textural changes. Antibiotic ointment, hydrocortisone 1%, or Aloe Vera gel may be used for a few days after treatment. I have been informed that scarring, blistering, purpura, hypo-pigmentation (lightening of the skin) or hyper-pigmentation (darkening of the skin) are possible risks and complications of this procedure, and may occur up to two weeks from the treatment.

I understand that avoiding exposure to sun for two weeks pre and post treatment is necessary to avoid complications. If complications occur, they are usually temporary and can be resolved, but skin discoloration may be permanent. If hyperpigmentation occurs, a bleaching cream may be prescribed to reduce the pigmentation. I will contact Aesthetic Specialists with questions, or if I suspect that a complication is developing. I consent to the taking of photographs during the course of my therapy for the purpose of medical education and /or the professional evaluation of treatment progress. I understand that my identity will not be revealed on these photographs or corresponding text.

I have read and understood all information presented to me before signing this consent.

Signed: _____ Date: _____
(Patient or person legally authorized to consent for patient)

Witness: _____ Date:_____
(To patient's signature)