



## **INTENSE PULSED LIGHT-BASED TREATMENT INFORMED CONSENT FORM**

Laser Hair Removal / Laser Hair Reduction: The Intense Pulse Light (IPL) Laser emits a gentle beam of light energy that passes through the skin and targets the melanin inside the hair follicle. With the follicle destroyed, it leaves the surrounding tissue healthy and unchanged and hair free.

Photofacial: Erase freckles, age spots, spider veins, sun damage, enlarged pores, redness and flushing (rosacea), and irregular pigmentation. The IPL Laser targets imperfections on the surfaces of the epidermis. The skin tone will have a more even look and feel, sunspots will fade and pore sizes will shrink. These improvements will steadily increase with each treatment. Before undergoing an IPL treatment, carefully read the following statements.

\_\_\_\_\_ I authorize \_\_\_\_\_ to perform intense pulsed light hair removal, pigmented lesion or vascular lesion and/or photofacial treatment on me. I understand that the procedure is purely elective.

\_\_\_\_\_ I understand that for hair removal treatment average hair loss is on average about 70-95%, may require anywhere from 4 -10+ treatments depending on several factors; energy level tolerance, hair color, location and amount.

\_\_\_\_\_ I agree to pay the individual and package fees quoted to me and all fees are non-refundable.

I understand \_\_\_\_\_ cancellation Policy requires 24-hour advance notice of any cancellations. If 24 hour notice is not given I will be charged 50% of the service fee and if I no call no show 75 % of the service fee will be charged and due before I may schedule again. If I am late, my appointment will be shortened in order to be finished in time for the next client. Depending on how late I am, we will determine if application can be started. You will be charged for the full session regardless of your application time.

\_\_\_\_\_ I understand that serious complications are rare but possible. Common side effects include temporary redness and mild "sunburn" like effects that may last a few hours to 3-4 days or longer. I understand that treatment of benign pigmented lesions and vascular lesions cannot be accomplished without producing some epidermal damage and that this may take 2-4 weeks to resolve.

\_\_\_\_\_ Pigment changes (light or dark spots on the skin) lasting 1-6 months or longer may occur. In addition, freckles may lighten and/or temporarily or permanently disappear in treated area. There is the likelihood of coincidental hair removal when treating pigmented/vascular lesions in hair bearing areas.

\_\_\_\_\_ Other potential risks include blistering, crusting, itching, pain, bruising, skin whitening, burns, infection, scabbing, scarring, swelling, and failure to achieve the desired result. Intense light can cause eye injury and protective eyewear must be worn during treatment.

\_\_\_\_\_ I understand that sun exposure or use of tanning lamps or self-tanning creams and not adhering to the pre- and post-care instructions provided to me may increase my chance of complications.

\_\_\_\_\_ I understand the importance of having an accurate diagnosis by a physician of brown spots prior to treatment, as treatment of an undiagnosed skin cancer may delay proper medical care.

\_\_\_\_\_ I understand that since hair follicles generally grow at angles within the skin, it is possible to affect follicles that are not directly in the beam's apparent path at the skin surface, and for that reason it is not advisable to shape or sculpt precise hair bearing areas such as eyebrows, etc.

\_\_\_\_\_ I consent to photographs being taken to evaluate treatment effectiveness, for medical education, training, professional publications or sales purposes. No photographs revealing my identity will be used without my written consent. If my identity is not revealed, these photographs may be used and displayed publicly without my permission.

Before and after treatment instructions have been discussed with me. The procedure as well as potential benefits and risks have been explained to my satisfaction. I have had all my questions answered. I freely consent to the proposed treatment.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_

Provider Signature \_\_\_\_\_ Date \_\_\_\_\_