Agapé
MEDICAL SPAS

Informed Consent for Laser Hair Removal

The purpose of this procedure is to diminish or remove unwanted hair. During this procedure, laser light is attracted to the melanin in the hair follicle; particularly in the bulb and bulge. Heat is collected there damaging the cells in the hair follicle with the potential to also damage the vascular matrix preventing future hair from growing.
Since hair has several cycles of growth and a certain number of hairs are only growing at a particular time, multiple treatments spaced appropriately apart will be required for maximum results. Particularly in females, hormonal changes can also affect treatment progress.
Unfortunately, there are no guarantees in laser hair reduction. There are clinical studies showing improvement of up to 80-90%, but results of total efficacy will vary from patient to patient.
During treatment patients may experience slight discomfort. A cryogen spray skin cooling device will be used to decrease discomfort and protect the skin.
During treatment the eyes will be covered with protective laser-specific safety eyewear. Eyes should remain closed, and eye protection must not be removed during treatment.

Possible risks and complications of this procedure include but are not limited to:

- Itching & redness (Hive-like response which may last 2-3 hours to 2-3 days or more)
- Herpes Simplex Virus activation (Applies to patients with and without a history of Herpes Simplex outbreaks)
- Burns, blisters, or scabbing
- Hyperpigmentation (Darkening of the skin; May be transient or long term)
- Hypopigmentation (Lightening of the skin; May be transient, long term or possibly permanent)
- Scarring (Rare but possibly permanent)

Alternative methods of treatment for hair removal/reduction are waxing, shaving, electrolysis and chemical epilation. These methods have been discussed with me such that I may assess the risks and benefits of these alternate treatments.

Previous Laser Treatment: (If applicable, specify date/number of treatments/body areas treated/frequency/tissue response/device used, if known) _____

_____

_____

Previous Hair Removal History: (circle any applicable)
Wax Plucking Shaving Chemical Epilation Electrolysis Bleaching

Frequency and Last Use of above modalities:_____

Do you have any implants, injectables or permanent makeup? If so, please list:_____

_____

Do you have any tattoos? If so, please list location(s):_____

_____

Tanning History (including direct sun, self tanners, spray tans) Please list and include last dates of use:_____

_____

_____

I understand that immediately following the laser treatment redness, swelling, discomfort and discoloration may develop at the treatment site. I understand that any discolorations may last 7-14 days and swelling should resolve within several days. Discomfort may be treated with the application of cool compresses or topical soothing agents.

I will be given complete instructions regarding after care of the treated area. It is important to follow after care instructions carefully to minimize the chance of side effects or complications. Daily use of a sunblock is HIGHLY recommended! **Direct sun exposure and tanning MUST be avoided, especially 2 weeks pre and post treatment.**

Please Initial:

_____ I have accurately provided my past and current medical history and medications.
_____ If deemed necessary for healthcare records, I consent to the taking of photographs during the course of my laser therapy.
_____ I am not currently pregnant or breastfeeding. (Female Patients)
_____ I have received an Instruction Sheet with Pre & Post Treatment information, and I agree to follow all instructions as stated for optimal safety and results.
_____ I acknowledge that there are NO GUARANTEES regarding the efficacy of this procedure.
_____ Patient being treated is at least 14 years of age or older.

I have been given the opportunity to ask questions about the procedure. My questions have been answered, and I understand the information given to me.

Contraindications to the performance of this procedure have been discussed in detail with me.

I recognize that the practice of medicine is not an exact science and acknowledge that no guarantees have been made concerning the results of such procedures.

I have read and understood all information presented to me before signing this consent form. I hereby authorize Agape Medical Spa's Certified Laser Professionals to perform Laser Hair Reduction treatments on me.

Patient/Guardian Signature:_____ Date:_____

Technician Signature:_____ Date:_____