

Informed Consent for Hair Removal Treatment

___ 1. I, _____, consent to and authorize Image Perfect Laser, Inc. to perform multiple treatments, light and/or laser procedures and related services on me.

___ 2. The nature and purpose of this treatment(s) have been explained to me as the laser removal or reduction of unwanted hair, and questions I have regarding the treatment have been answered to my satisfaction.

___ 3. I understand that the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks. Although rare, some possible complications that may present are:

- Bruising
- Infection
- Blistering and graying of the skin: it may require a few weeks to heal. Scabs may form at the site of blisters, and may result in pigment changes.
- Scarring is a rare complication. Possibly from infection or blistering.
- Change in skin color: Almost always temporary, but can be minimized by following the pre and post treatment instructions.
- Eye damage: You are required to wear protective glasses at the time of the treatment. Laser can damage your vision if not using the special glasses.

___ 4. Although we have not seen permanent complications with our laser, patients with the following conditions are at a higher risk: Tanning within the preceding six weeks: active skin infection or history of herpes simplex or shingles in the treatment area, history of keloid scarring, use of Accutane within the preceding 12-18 months, current use of photosensitive antibiotics/medications.

___ 5. The means of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment. I understand that there are other options of hair removal, although less effective, such as electrolysis, waxing, and chemical preparations.

___ 6. It has been explained to me that expected results may vary depending on both hair type and skin type. I understand that multiple treatments at a regular scheduled interval will lead to the best results. Every individual's treatment response is different: therefore, I understand that no guarantee, warranty or assurance has been made to me as to the results that may be obtained. I am aware that follow-up treatments may be necessary for desired results.

___ 7. I agree that any pictures taken of my treatment site may be used for the purpose of monitoring my progress.

___ 8. I understand there is a 24 hour cancellation policy. A \$50.00 minimum fee for every 30 minutes of appointment reserved or the loss of one treatment in your package will be charged: whichever is greater, if I fail to show or do not cancel at least 24 hours prior to my scheduled appointment.

___ 9. I understand that once I've started my treatment program under the package pricing, there are no refunds.

___ 10. I certify that I have read this **Informed Consent** and that I understand and agree to the information provided in this form. I certify that I am a competent adult of at least 18 years of age. This **Informed Consent** is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns.

___ 11. I agree to adhere to all safety precautions and regulations during the laser treatment.

___ 12. I agree to disclose any changes in my medical condition and medication list upon any applicable subsequent visits.

Client/Patient
Signature _____

Date _____

Staff Signature _____

Date _____