Southwest Family Physicians Laser Consent Form

I hereby authorize Southwest Family Physicians to perform non-medical hair reduction or other skin pigment, texture or vein treatments with the Candela Gentle YAG, Gentle LASE or Smoothbeam Laser on me.

I have been informed that **Laser Hair Removal** is a procedure by which hair from the body is **permanently reduced by approximately 75% to 95%.** The Candela GentleLASE (1455nm) or NdYAG (755nm) lasers are both devices that produce an intense but gentle burst of burning light that selectively destroys hair (or blood vessels) without harming the surrounding tissue. The laser works by disabling only the hairs that are in their active cycle at the time of the treatment - this is why multiple treatments are necessary: to catch different hairs as they rotate through their respective active phases.

I understand that I will have to wear **protective eyeglasses** during the course of the treatment to protect my eyes from the intense laser light. _____

I am aware that immediately following the laser treatment I can expect the following treated area to become red and swollen. This may last for up to three weeks. Treatment can produce, but is not limited to the following short-term but common side effects: burning sensation, welting, itching, tingling, and dry skin. The treated area may feel like a sunburn. I understand that these side effects usually last from 2 hours to a couple of days. _____

I understand there are less common risks and complications that can occur from a laser treatment that can interrupt my daily life, work routine, or social life. These may include but are not limited to: deep burning, blistering, scab formation, heat rash, bruising, scarring, purpura, infection, hypopigmentation (lighter skin), and hyperpigmentation (darker skin). These may, rarely, become permanent. If any of these were to occur, I understand that our affiliated physicians are available to see me and provide post-treatment guidelines to speed my recovery time. If hyperpigmentation occurs, a bleaching cream may be prescribed to reduce the darker pigmentation. If I choose to consult my own physician or seek any other medical attention, it is at my own expense. _____

For best results, I have been informed that **multiple treatments** will usually be needed. For most areas of hair reduction, 6 to 8 treatments are necessary to achieve desired hair clearance. I understand that more than 8 treatments may be needed depending on hair type, previous methods of hair removal, and skin color. I understand results are not guaranteed. Some of the factors that could trigger new hair growth are hormonal changes, pregnancy, medications, menopause, tweezing, or waxing. Clinical results vary with different skin types, hair color, and the location on the body. _____

I understand that I **may not tan during the course of my laser treatments**, because this can cause a number of complications. I understand that I should **avoid direct sun exposure for 2 weeks** after my laser treatment and that this also includes tanning beds. I have been informed to use a sun block with an SPF of 30 or higher on the treated area during the full course of the laser treatments. I understand it is my responsibility to inform Southwest Family Physicians if my skin is any darker than when treatment first started. I have made Southwest Family Physicians fully aware of any use of tanning beds, sunless tanning products, or unprotected exposure to the sun in the last 14 days. _____

Antibiotic ointment may be used for a few days after treatment or possibly only aloe vera gel. I understand **post-treatment** care is very important after the treatments and I will adhere to all the instructions give to me. Improper care to the treated area may increase the chance of scarring, skin texture changes, or other permanent complications. _____

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I consent to having photographs taken during the course of my laser treatments to be retained as part of my file at Southwest Family Physicians for the purpose of documentation and medical education. I understand all photographs are the property of Southwest Family Physicians and are kept strictly confidential. _____

Anesthesia is usually not necessary as these Lasers use a powerful cooling device that delivers cooling liquid spray to the surface of the skin simultaneously with the Laser firing. If additional anesthesia is needed , all options will be discussed with me. _____

I confirm that I am not pregnant at this time and I do not have a pacemaker or internal defibrillator. The medical history and other information I have provided is true and complete to the best of my knowledge and I agree to inform Southwest Family Physicians of any changes. _____

I will not hold Southwest Family Physicians, its owners, or its employees responsible for the hair reduction or skin treatment results I experience. I realize that my skin and hair is an organ unique to me and that therefore results may vary. I further understand that Southwest Family Physicians cannot prescribed an exact number of treatments to satisfy each individual's opinion and that the number of treatments I complete will be at my own discretion. _____

I understand that there are other options for hair removal, vein treatment, and/or skin rejuvenation such as electrolysis, waxing, vein injection or stripping, and chemical preparations, rather than laser treatment. With this in mind, I choose laser treatments with Southwest Family Physicians as a non-invasive treatment for epilation and/or skin rejuvenation. _____

I understand that my treatments by Southwest Family Physicians require payment in advance and the prices and fee structure for treatment have been explained to me. **There are no refunds on treatments, or on treatments paid in advance: _____**

I further understand that the quoted price for treatment is the price for each individual treatment or session, unless otherwise specified in writing. I understand that laser hair reduction services requires more than one treatment session, depending on the individual, and that the price quoted to me for treatment is only the price for each individual treatment session, unless, again, otherwise specified in writing. _____

I am fully aware that my condition is solely a cosmetic concern and that the decision to proceed is based on my expressed desire to do so. _____

I am aware that Southwest Family Physicians requires 24 hours notice of a cancellation or of a need to reschedule and that is my responsibility to provide that notice. I agree to pay a minimum of $75.00, or half of the scheduled treatment cost, if I fail to give the 24 hours notice. If I choose to prepay my treatment session or sessions, I understand that I may forfeit one of my future sessions if I do not provide Southwest Family Physicians proper notice (24 hours). _____

I have read and understood all information presented to me before signing this consent. I have had ample opportunity to ask questions regarding laser hair reduction or other treatment, side effects, aftercare, and all of my questions have been answered to my satisfaction. I also understand it is my responsibility to inform Southwest Family Physicians of any medical or prescription changes.

Signed: _____ **Date:** _____

(Patient or person legally authorized to consent for patient)

Witness: _____ **Date:** _____

PRINT CLIENT NAME: _____