

LASER HAIR REMOVAL: INFORMED CONSENT

Patient Name: _____ **Date:** _____

Diagnosis: Hypertrichosis PFB Other: _____ **Location:** _____

I consent to treatment with laser hair removal in an effort to treat unwanted hair growth. It has been explained to me that, although laser surgery is effective in most cases, no guarantees can be made that I will benefit from treatment. I understand that several treatment sessions are usually needed in order to obtain the desired level of improvement. Sometimes, hair growth will return, but it will be lighter and thinner. Rarely, hair growth may not respond to laser treatment at all. I understand that unwanted hair growth is a cosmetic problem that does not pose a medical threat if left untreated. The most common side effects and complications of laser treatment are:

- 1. Pain.** The snapping and burning sensation of each laser pulse can produce a minimal to moderate amount of discomfort. An anesthetic cream or injection can sometimes be used to block the pain if desired.
- 2. Redness and swelling:** Redness and swelling in the treated area usually subside within several days.
- 3. Skin darkening (hyperpigmentation), skin lightening (hypopigmentation), and/or mottled discoloration:** Darkening or lightening of the skin can occur in the treated areas and will usually fade within 2 to 6 months, but in rare instances, could be permanent. This reaction is more common in patients who are suntanned or who have olive or darker skin tones. It can result or worsen when laser treated areas are exposed to the sun. This risk can be minimized by avoiding treatment of suntanned areas of skin and adhering to postoperative instructions.
- 4. Patchy or incomplete hair removal or hair persistence:** In rare cases, unwanted hair may not respond or go away completely despite our best efforts. No guarantees can be made regarding any individual's response to laser therapy. In general, hair that responds best to treatment is dark in color. Typically, light hair (gray, white, or blonde) will not respond. It is expected that periodic re-treatment will be necessary to maintain results.
- 5. Infection:** Swelling, crusting, pain, or fever could indicate an infection or reactivation of cold sores or fever blisters. This may require use of topical or oral antibiotics.
- 6. Paradoxical increased hair growth:** There have been rare reports of increased hair growth occurring in areas treated with laser hair removal. This is an unusual response to treatment and cannot be predicted.
- 7. Blisters, bruising or crusting:** These are uncommon responses to treatment and can take 1 to 2 weeks to resolve.
- 8. Scarring:** This is extremely rare after laser hair removal, but could occur on disruption of the skin's surface. Carefully adhering to all advised postoperative instructions will reduce the possibility of this occurrence.

	PLEASE INITIAL
I have read and understand this consent form.	
I have had the opportunity to ask questions.	
My questions have been answered to my satisfaction.	
I understand the nature of the procedure, its risks, and alternatives including no treatment.	
I understand that multiple treatments are necessary for optimal results and that it is impossible to predict how my hair will respond to laser treatment.	
I certify that I am not pregnant, trying to become pregnant or breastfeeding and I accept the responsibility for making these determinations.	
I am aware that the practice of medicine and laser surgery is not an exact science and I acknowledge that no guarantees have been made to me regarding the procedure.	
Consent for Photography: For the purpose of documenting my progress and response to treatment, I give permission to take photographs that will be kept in my medical record.	
I give permission for the use of my photographs to further medical education.	

COST AND PAYMENT POLICY: Since laser hair removal is considered cosmetic, you will be responsible for the cost of treatment. Full payment is due at the time of service. Unfortunately, credit cannot be extended. Please discuss the estimated cost of treatments prior to undergoing the procedure. Your treatment may be more or less than the estimate depending on the areas treated. If you have any questions, please make sure they are answered to your satisfaction.

ESTIMATED COST OF TREATMENT: _____

I certify that I have read and understand the contents of this consent form before signing my name below. I hereby freely consent to laser treatment in an effort to treat unwanted hair.

Signature of patient or legal guardian *X* _____ **Date** *X* _____

Witness: _____ MD Signature: _____ Date: _____