Client LASER consent form		Date:	
Name		Date of birth:	
Address: City:		State	e: Zip:
Address: City: Cell Phone:		E-mail:	
Emergency C	Contact:		
What services are you interested in ?		☐ Body Contouring	□ Skin tightening
□ Hair removal □ Botox □ Chemincal Peel		□ Acne Treatment	□Age Spot removal
□ Wrinkle reduction □ Massage □ Nails		□ Weight management □ Filler	
How did you find us?:			
	Health History		
Circle YES or NO			
YES NO	Any Allergies?  Are you currently on any mood altering or depression medication? Have you ever used ACUTANE? If yes when did you last use it?  Are you pregnant? Are you breastfeeding? Do you have HIV? Do you have keloid formation or scars that haven't healed smoothly? Do you have cold sores? If yes, date of last breakout  Do you have Hepatitis? Do you have a tattoo(s) in the area(s) that you want treated? Have you sunbathed, been in a tanning bed or spray tanned in the last 2 weeks? Does your skin remain discolored after healing from a cut? Have you taken antibiotics in the past 2 weeks?		
that it is my this history	t the information regarding my medical, p y duty to make the technician aware of an as necessary. I am aware that the technic tment procedures.	y current medical or healt	h issues I may have and to update
transient redr hours to up to	y are rare, I am aware that significant issues caness, swelling, and mild reactions that resemb o four days. Other potential risks include infections burns, infections, hyper- or hypopigmentat	le sunburns. The duration of tions, blisters, scabbing, hype	these effects can range from a few o- or hyperpigmentation, scarring,
-	taken to document treatment progress I give r purposes without payment or consideration.		romotional or advertising and
Client's Signature:			Date:
Therapist's Signature:			Date:

## **Treatment Consent about Results** \_ I understand That the laser is intended for hair removal and that clinical result may vary with different skin type, hair color, and location. Although they are rare, I am aware that significant issues can happen. In the treated area, common side effects include transient redness, swelling, and mild reactions that resemble sunburns. The duration of these effects can range from a few hours to up to four days. Other potential risks include infections, blisters, scabbing, hypo- or hyperpigmentation, scarring, discomfort from burns, infections, hyper- or hypopigmentation, and failure to achieve the intended result (s). I am aware that I must cease using depilators, waxing, bleaching, tweezing, and other methods that could harm my hair follicles. I am aware that before receiving treatment, I must shave, trim, clip, or otherwise remove any surface hair. $\_$ I am aware that getting too much sun should be avoided for at least two weeks before and two weeks after treatment. The laser technician may decide to delay treatment if there is a tan or sunburn on the patient. \_I understand that the effectiveness of my treatment is dependent upon the presence of melanin in my hair; therefore it will not be effective on white, grey, or blond hair. I understand that I cannot have treatments if antibiotics have been taken within the last 2 weeks prior to treatment and I cannot have treatments while being pregnant or breastfeeding. I am aware that changing drugs or taking supplements can impact how well laser treatments work, and I will let the technician know before each session. Date Change Y/N Initials Changes Y/N Initials Date