Hair Reduction/Modification with The EpiLaze Diode Laser System Consent Form

I, _____, authorize and consent to the treatment of Hair reduction/modification with the EpiLaze Diode laser System. I have been advised by, _____ of Luxe Medical, of the purported advantages and disadvantages associated with this treatment.

I. ACKNOWLEDGMENT OF RISKS AND LIMITATIONS

- I understand that treatment with this laser system varies from patient to patient and that more than 1-treatment may be required.
- Although rare, adverse outcomes such as hyperpigmentation and/or hypopigmentation (darkening or lightening of the skin), skin texture changes, and trace scarring can occur.
- I understand that the list of potential adverse outcomes provided is not exhaustive, and I accept the risk of other unforeseen or rare complications that may arise.
- No guarantees have been made to me regarding the outcome of the treatment or any improvements in my condition due to the procedure.
- I acknowledge that the possible benefits are the reduction of unwanted body hair, and possibly the elimination. I understand that complete and permanent elimination is not guaranteed and that future maintenance treatments may be necessary to sustain results.

II. EYE PROTECTION AND FINANCIAL RESPONSIBILITY

- Due to the brilliance of the laser light energy used, I agree to wear eye protection to shield my eyes. I confirm that I will keep the provided eye protection on for the entire duration of the laser application.
- I understand that each treatment session will incur a separate charge, and I am solely responsible for the financial costs of all required treatments, including any necessary follow-up or corrective procedures.

III. INDEMNIFICATION AND ADHERENCE TO PROTOCOL

- I affirm that I have provided a complete and accurate medical history. I agree to strictly adhere to all pre-treatment and post-treatment instructions provided by Luxe Medical. I understand that my failure to follow these instructions may increase the risk of complications.
- I hereby indemnify and hold harmless Luxe Medical from any and all liability, damages, cost and expenses arising from or out of the use EpiLaze Diode Laser System for treatment of hair reduction, removal. I agree that Luxe Medical shall not be held liable for complications resulting from my non-adherence to instructions. _____ (Initials)

IV. PATIENT ACKNOWLEDGMENTS

I have been given the opportunity to ask questions and have received satisfactory answers to those questions. _____ (initials)

I hereby authorize the taking of photographs. _____ (initials)

With all of the above information understood, I am choosing to be treated with the EpiLaze Diode laser System.

Patient: _____ Date: _____

Witness: _____ Date: _____