Client Informed Consent: Laser Hair Reduction Therapy

Please read this form entirely. This form contains information to assist you in making an informed decision whether or not to have laser therapy performed upon you. Initial the blank space to the left of each paragraph if you understand it. If you do not understand it, do not initial it and your Counselor will discuss the information with you.

____**LASER** is an acronym that means Light Amplification by Stimulated Emission of Radiation. It is an intense beam of light. A “Therapy” is a treatment of a disease. A “disease” is an abnormal condition in an organism. All humans are “organisms”. A Certified Laseographer will perform the Therapy. A “Certified Laseographer” is a person who has been trained, tested and Certified as competent by a Qualified Certifying authority in the provision of Laseographic treatments. “Laseographic” refers to “Laseography”, a science defined as, “the Art of Laser”. Some Laser Therapies have been found to be useful to cause a reduction of the quantity of unwanted hair in treated areas. Laser Therapy is one of the most advanced methods for the removal of unwanted hair, but it is not an exact science. While hair quantity reduction is expected to occur, no guarantees can be made of the exact results from this therapy. There are risks and complication that may result from this therapy,They are rare, but do exist and you must be aware of them. These risks, complication sand concerns include:

____**PAIN**. The procedure is not painless. The sensation has been described as warm and sharp. Skin cooling treatments will be used to minify discomfort.

____**SCARRING AND CHANGE OF SKIN COLOR**. Scarring is possible. Normally, Laser Hair Reduction Therapy does not result in scarring, but it is possible. All efforts are made to reduce or eliminate any potential for scarring. Hyperpigmentation (a darkening in the color of the skin) or Hypopimentation (a lightening of the color of the skin) may occur, but neither is expected. If either occurs, steps can be taken to reduce the effects. Left untreated, either effect normally lasts three or four months, but can be permanent in rare situations.

____**BLEEDING, INFECTIONS OR CARCINOGENIC REATIONS**. This Laser Therapy does not involve puncturing of the skin or blood vessels. Minor bleeding may occur, but it is unusual. Deep injury is extremely unlikely because the laser energy only penetrates the skin a few millimeters. Infections are rare but may occur in isolated circumstances. According to medical literature, this Laser Therapy cannot contribute to a carcinogenic reaction in living human tissue in any known way.

____**TREATMENT EXPECTATIONS**. You will need multiple treatments to achieve the desired results. Due to hair and skin growth cycles, Multiple treatments will be needed for complete hair removal. You should expect a reduction in quantity of unwanted hair in an area treated. Exact responses will vary from person to person. While removal of unwanted hair is expected, it is possible that no results may occur for reasons beyond the Certified Laseographer o r Physicians” control.

____**APPEARANCE**. After Laser Therapy, swelling or welts may appear over the area. Also, redness, scabbing, Photosensitivity and blistering are possible for a few days following the therapy. Blistering occurs in less than 2 % of all treatments. If it does occur, normal first aid treatments should be administered.

____**NO GUARANTEES**. As indicated earlier, there can be no guarantee as to the exact results of receiving this therapy. The percentages of improvement or permanency of the results are not in any way guaranteed, however Laser Therapy represents one of the most advanced technologies available for the permanent reduction or removal of unwanted hair. You should be aware that the exact effect will vary from person to person.

____**OTHER INFORMATION**. Follow the Post Therapy Care Instructions precisely after the treatment.

I have read the foregoing information, it has been explained, and I understand it. All of my questions have been answered. By executing this form, I am indicating that I have no question s whatsoever and I give my full informed consent to have Laser Hair Reduction Therapy performed.

DATED this _____day of _____________20____ X____

(Client or Legal Guardian)

I have received and understand the pre/post care instructions. ___________