

# **INFORMED CONSENT**

## **Laser Treatment for Hair Removal**

**Patient's Name:** \_\_\_\_\_

I clearly understand and accept the following:

1. The goal of this treatment is improvement, not perfection. I understand there will be some hair left at the end of my treatments. The amount of hair that is remaining will be relative to the fluence (energy I can tolerate, the colour, amount and location of my hair. Average loss at the end of consecutive sessions is 70-95% less hair. Up to 20% of the population will not respond to any laser or light treatments. This cannot be determined until after the second to fourth treatments.
2. There may be more treatments necessary than I anticipated
3. The Laser studies have shown to reduce hair permanently, but results can vary from person to person.
4. I agree to pay the fee quoted and understand that all fees quoted are non-refundable.
5. I agree to have clinical photos taken of the area to be treated.
6. Studies and experience with this technology have shown there to be some potential complications and side effects:
  - 10-20% chance of developing hypo and/or hyperpigmentation
  - Purpura, blistering, crusting, scars, keloids, hives
  - Freckles and brown spots may lighten or disappear
  - Pimples
  - Redness and swelling
  - Purple mottling discolouration can occur with hair removal on legs
  - New reports are documenting the incidence of increased growth of facial hair on females, especial in the neck area and it may not resolve with further treatments
  - There is the risk of temporary discoloration of the skin. The effects may be permanent but the incidence is less than 5%. Ulceration or scarring of the treatment area is very rare.
  - New hair growth
  - Infection – Albeit rare, skin infection is a possibility any time a skin procedure is performed. I acknowledge and understand that although rare, it is possible for a skin infection to become a blood-borne wide spread infection.
  - Although uncommon, I could possibly develop an allergic reaction to medicines applied to the treated area and that I could possibly develop an allergic reaction to any medications that may be prescribed for me.
7. I understand that if I have a history of cold sores or genital herpes I may require pre and post treatment with anti viral medications.
8. I agree that I have not tweezed, waxed, threaded or had electrolysis for the past 4 weeks and will not use these methods during the laser treatments.

9. I agree not to tan or using tanning beds or self tanning creams while undergoing Laser treatments. I agree to protect my skin with a minimum of an SPF 30 for 2 months post treatment.
10. I understand that my medication \_\_\_\_\_ which is known to be photosensitizing increases my chance of developing blisters. I am willing to accept that risk.
11. I understand that to have the best result possible I agree to the treatment intervals as the clinic designs for me. I agree to follow post care instructions.
12. The clinical evaluation of laser epilation data suggests that most patients achieve delayed hair regrowth or a permanent reduction of hair growth in the treated areas. Some patients experience little or no regrowth after 8 treatments. On average, patients complete 6-10 treatments to cause a permanent reduction in hair growth. A small percentage of patients may be non-responders and will experience significant regrowth, even after several treatments. A number of patients do well with treatments however you may need occasional maintenance sessions.
13. I understand that I need to come in on a regular basis to have the treatments be effective. That is, once the hair in the treated area begins to regrow, I should have my next appointment within a month. I understand that long delays between treatments will lessen the effectiveness of the laser.
14. I am fully aware that my condition is of cosmetic concern and that the decision to proceed with treatment is based solely on my expressed wish to do so.
15. I certify that I have no excessive scarring, keloids, and have not taken Accutane for at least one year.
16. I understand that after the 10<sup>th</sup> treatment, if I still have hair growth, I may need more sessions.
17. I realize that hormone problems can lessen the effectiveness of therapy.
18. I understand that although complications are very rare, sometimes they may occur and that prompt treatment is necessary. In the event of any complications, I will immediately contact the doctor/technician who performed the treatment.
19. I understand that the hairs should be shaved the day prior to laser treatment.
20. I have had the process thoroughly explained to me. I understand the potential benefits and complications and willingly agree to undergo Laser treatments to reduce my body hair.
21. I have been given the opportunity to ask questions and hereby certify that I have read and fully understand the contents of this consent form and information package before affixing my signature below.
22. I duly authorize Dr. Antony S. Nield and/or the Technician to perform the laser procedure and any other measures which in their opinion may be necessary.

**Patient's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Witness:** \_\_\_\_\_