LASER HAIR ASSOCIATES
OF ROCKLAND

INFORMED CONSENT FOR LASER HAIR REMOVAL

Client's Name: ____ Date: _______________

The purpose of laser hair removal is to diminish or remove unwanted hair. This procedure requires more than one treatment session. Most clients will need between 6 – 8 sessions. The total number of treatment sessions may vary among individuals. On rare occasion there may be a client that does not respond to treatment.

I authorize Laser Hair Associates of Rockland, Inc. and its designated staff to perform Laser Hair Removal on my body. I understand that Laser Hair Removal is an FDA –approved treatment method for removing unwanted hair. I have been advised of the possible adverse reactions which are as follows:

1. **Short term effects** may include reddening, swelling, bumps, mild burning, temporary bruising or blistering. Hyperpigmentation (browning of skin) and Hypopigmentation (lightening of skin), although rare, may occur. These conditions usually resolve within 3 – 6 months, but permanent color change is a rare risk, less than 1%. Avoiding sun exposure before and after treatment reduces the risk of color change.
2. **Infection** following treatment is quite unusual, but bacterial, fungal and viral infections can occur. Herpes simplex virus infections around the mouth can be stimulated by laser treatment. This applies to both individuals with a past history of herpes simplex virus infections and individuals with no known history of herpes simplex virus infections in the mouth area. Should any type of skin infection occur, additional skin treatments or medical antibiotics may be necessary.
3. **Allergic reactions**, although very rare, may occur. Local skin allergies to topical preparations, tape, or preservatives used in cosmetics can occur.
4. However slight, there is a **risk of scarring.**
5. **Pinpoint bleeding**, although very rare, may occur following treatment procedures. Should bleeding occur, additional skin treatment may be necessary.
6. **Eye protection** must be worn at all time because exposure to laser light could harm one's vision.

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival to the office. Please be understanding if we cause you any inconvenience.

By signing below, I acknowledge that I have read the adverse reactions above and I feel that I have been adequately informed of the risks of Laser Hair Removal treatments. Before each treatment I will inform the laser technician if I have taken any new medications since my last treatment or if I have tanned the areas to be treated either by sunlight or artificially. I understand that tanning and some medications can make my skin photosensitive. I also understand that either of the formentioned conditions could cause the laser to damage my skin. I also agree to comply with the recommended aftercare instructions which are crucial for healing and prevention of scarring and hyperpigmentation. I hereby release Laser Hair Associates of Rockland, Inc. and its designated staff from liability associated with the above.

ACKNOWLEDGEMENT:

My questions regarding the Laser Hair Removal procedures have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release Laser Hair Associates of Rockland, Inc., Lori Giachetti, Kristine Santoro, and Christine Liscio from all liabilities associated with the above indicated procedure.

Client/Guardian Signature: ____ Date: _____________

Laser Technician Signature: ____ Date: _____________