

Patient Consent for Laser Hair Reduction- Aileen Plus

Name: Mrs./ Mr. / Ms.
Address:
Patient ID: Phone Number:

I _____, here by authorize Dr. _____ or his trained assistant to operate on myself or on _____, who is my _____ (relation) for _____. Initial _____.

Treatment Area: _____ **Indications:** _____
Machine Used: _____

Laser hair reduction involves using a noninvasive laser device for long term reduction of facial or body hair. This procedure requires more than one treatment session. Even after multiple sittings, 100% reduction [hair free skin] is not possible. The hair will reduce treatment in numbers and thickness. Maintenance treatments may be required after completion of treatment.

The total number of treatment sessions may vary among individuals. Exact number of sessions cannot be predicted. Patients with darker skin may require a greater number of treatment sessions and may be more prone to adverse effects.

Hair shafts may be expelled out during the 2-3 weeks following treatment and may mimic the appearance of regrowing hair. These may be left to fall out, or they may simply be shaved. If a patient develops growth in areas in distant regions other than the region treated, it could be due to underlying detectable or undetectable hormonal problem and if those areas are also to be covered by treatment, patient will have to bear the cost of treatment.

I am aware of the following:

1. The **adverse events like** stinging or burning sensation, redness resembling a sunburn (The redness will typically subside in 1 to 6 weeks but could last longer), swelling (subsides in 1 to 2 weeks), skin darkening in the treated areas and will usually fade within 1 to 6 months (rare), skin lightening (It usually re-pigment in 1 to 6 months, but in rare cases could be permanent), blisters or scabs, infection, acneiform eruptions, scarring, allergic reactions and even risks or complications associated with this treatment that are not yet reported in the literature. **Increased hair growth in or around the treated area** is a very rare consequence of Laser Hair Removal (Reason not known). However, these hairs can also be reduced with same laser.
2. The potential benefits of the proposed procedure and possible **alternate procedures** like other laser treatments, intense pulsed light therapy, electrolysis, shaving, waxing and plucking and taking no treatment at all.
3. No **guarantee**, warranty, or assurance has been made to me as to the results that may be obtained and that for maximum and optimum results, several treatment sessions may be required spaced at varying intervals.
4. I understand that **variable results** are seen due to the patients' lifestyle, medical profile, hormonal status (I give consent for hormone work-up), age, and genetic factors.
5. The need of regularity of treatments, **multiple sessions** or touch-ups and maintenance treatments in the future.
6. The need of proper **pre- and post- treatment care**. (The instructions given should be strictly adhered to).
7. The **cost of treatment** per sitting and the payment schedule. (I will be responsible for reimbursing the cost of the procedure as many of the procedures may not covered by insurance companies or companies).
8. The sensation of the procedure and on occasion, use of topical, block, local or general **anesthesia**. (I give consent for the anesthesia.)

I consent to the **taking of the photographs** during the course of my procedure for the purpose of proper documentation, publications, presentations and post-operative assessment. I give consent for that.

For the **women of childbearing age**: By signing below I indicate that I am not pregnant. Furthermore, I agree to keep the doctors informed should I become pregnant during the course of the treatment.

I will inform the doctor of all current **medications** and change in the medications during the course of treatment.

My **medical history** regarding active skin infection, impaired healing (e.g. keloid scar formers), and pregnancy.

I am giving consent that if anything goes wrong during the procedure, I may be given any **emergency treatment** best suited to me, without asking for my prior permission.

I further state that, I have carefully read and understood all the information provided in this form and with a fully conscious mind, I hereby give my written consent for the said procedure along with its involved risks.

The procedure, the side effects and the risks involved have been explained to me in my native language.

I hereby **release** Dr. _____ and its designated staff from liability associated with the above procedure.

Signature of the patient/ thumb impression

Signature of the Guardian (For Minors)

Name and relationship with the Guardian

Date

Witness 1

Witness 2