Laser Hair Removal Consent Form

Last Name:_____ First:_____ Middle:_____
Address:_____ City:_____
State: _____ Zip:_____ Date of Birth:_____Phone #_____
Email Address:_____
How did you hear about us ? _____
Primary Care Physician:_____ Phone:_____
Please list any medications, including prescription or over-the-counter medicines including vitamins, herbs, supplements_____
Are you Allergic to any medications?_____
Are you currently being treated for any medical condition?_____
Do you have any skin Allergies or Active skin diseases_____
Have you had skin cancer or precancerous lesions?_____
Have you had any previous laser treatments, skin treatments?_____
Have you used Accutane? Date last used?_____
Cosmetic procedures (chemical peel microdermabrasion, botox. collagen injections. sclerotherapy, micropigmentation-permanent-make-up, etc.) and last date of procedure:_____

Circle Yes or No:

Yes No 1.) Do you have cold sores? If yes, when was the last?_____
Yes No 2.) Do you have HIV?
Yes No 3.) Do you have keloid formation or scars that haven't healed smoothly?
Yes No 4.) Do you have any skin disorders e.g. psoriasis, vitiligo. skin cancer, sic.?
Yes No 5.) Are you diabetic or have endocrine disorders?
Yes No 6.) Do you have hepatitis?
Yes No 7.) Are you or could you be pregnant or breastfeeding?
Yes No 8.) Do you have any endocrine disorders?
Yes No 9.) Do you have polycystic ovarian disease, hirsutism thyroid disease?
Yes No 10.) Do you have heart, lung disease?
Yes No 11.) Do you have a pacemaker or defibrillator?
Yes No 12.) Do you have high blood pressure?
Yes No 13.) Do you take any medication that causes photosensitivity?
Yes No 14.) Do you have any clotting problems?
Yes No 15.) Have you ever had a DIT (deep venous thrombosis)
Yes No 16.) Do you have tattoos) in the area(s) or that you want treated?
Yes No 17.) Have you Sunbathed or been in a tanning bed within the last 2 weeks?
Yes No 18.) Does your skin remain discolored after healing from a cut?

Fitzpatrick skin type assessment

What color are your eyes? _____

0 – Light blue, gray, green

1- Blue, gray, or green

2 – Blue

3 – Dark Brown

4 – Brownish Black

What is your natural hair color? _____

0 – Sandy red

1 – Blonde

2 – Chestnut/ Dark Blonde

3 – Dark brown

4 – Black

What is your skin color (unexposed areas)?

0 – Reddish

1 – Very Pale

2 – Pale with a beige tint

3 – Light brown

4 – Dark brown

What happens when you stay too long in the sun _____

0 – Painful redness, blistering, peeling

1 – Blistering followed by peeling

2 – Burns sometimes followed by peeling

3 – Rare burns

4 – Never had burns

Do you have freckles on unexposed areas? _____

0 – Many

1 – Several

2 – Few

3 – Incidental

4 – None

To what degree do you turn brown? _____

0 – Hardly or not at all

1 – Light color tan

2 – Reasonable tan

3 – Tan very easily

4 – Turn dark brown quickly

Do you turn brown after several hours of sun exposure? _____

0 – Never

1 – Seldom

2 – Sometimes

3 – Often

4 – Always

How does your face react to the sun? _____

0 – Very sensitive

1 – Sensitive

2 – Normal

3 – Very resistant

4 – Never had a problem

When did you last expose your body to the sun sunlamp/tanning cream)? _____

1 – More than 3 months ago

2 – 2-3 months ago

2 – 2-3 months ago

3 – 12 months ago

4 – Less than a month ago

5 – Less than 2 weeks ago

Do you expose your face to the sun? *(for the purpose of this quiz we have changed this question from the original: Did you expose the area to be treated to the sun?)* **(or artificial _____**

1 – Never

2 – Hardly ever

3 – Sometimes

4 – Often

5 – Always

Total up your points and match your score below to find your skin type.

FITZPATRICK SCALE QUIZ SCORE

0-7 = Type I

8-16 = Type II

17-25 = Type III

25-30 = Type IV

Over 30 = Type V-VI

Total score number _____

Which of the following describes your skin type? Circle one:

1.. Always burn, never tan

2. Always burn sometimes tan

3. Sometimes burn, tan somewhat

4 Rarely burn, tan with ease

5. Moderately pigmented, never burn

Please circle your genetic origin: African American, Asian, Caucasian, Hispanic. Mediterranean. Middle Eastern. Native American, Other_____

Describe your skin. Check those that apply:

Oily___ Dry___ Combination___ Normal___ Sensitive___ Sun-Damaged___ Freckled Mature___Wrinkled___ Broken Surface Capillaries___ Hypo/Hyper Pigmented____Melasma___ Aged spots___ Rosacea____Eczema____Psoriasis___ Acne___ Scarred___Large Pores___ White/blackheads____Texture issues____

To the best of any knowledge, the information I provided is true. I understand that this information is confidential and will not be disclosed without my written consent..

Patient or legal Guardian Signature:_____

Laser Therapy Informed Consent

Please read this form entirely. This form contains information to assist you in making a decision to have laser therapy. Initial each paragraph if you understand it. If you do not understand it, do not initial and each paragraph will be discussed with you separately. There are risks and complications that may result from this therapy, they are rare. but do exist and you must be aware of them. These risks. complications, and concerns include:

_____Pain. This procedure is not painless. The sensation has been described as warm and sharp. Local anesthesia may be used for more invasive laser treatments as deemed necessary. Allergic reaction to anesthesia is a possibility

_____Scarring and change of skin color. Scarring is possible. Normal laser treatments do not result in scarring. but it is possible. All efforts are made to reduce or eliminate the potential for scarring Lightning Darkening in the color of the skin may also occur, but is not expected. If it occurs. it normally resolves with time. Additional treatments) may be necessary to treat scarring or discoloration.

_____Bleeding or infection. Minor bleeding may occur but it is very unusual. Deep injury is extremely unlikely because the energy only penetrates the skin a few millimeters. Infections are rare but may also

occur in isolated circumstances. Herpes Simplex Virus outbreaks can occur following laser treatment around the mouth. Prescription medication can be used to suppress the virus. According to medical literature, lascars do not contribute to carcinogenic reactions in living human tissue in any known way.

_____Treatment Expectations. Usually, you will need multiple treatments to achieve the desired results. Due to hair and skin growth cycles, multiple treatments may be needed. You should expect improvement in the appearance of an area treated, but flawless skin may not be the result. Responses can vary from person to person. While improvement may be expected no results may occur for reasons beyond the Nurse or Physician's control.

_____Appearance. After laser treatment redness, scabbing, itching, burning sensation, photosensitivity and blistering are rare but possible within the first 18 hours of treatment.

_____No Guarantees. There is no guarantee as to the cxact results of receiving laser therapy. Laser therapy represents one of the most advanced technologies available. You should be aware that the exact result will vary from person to person.

_____Burns or Eye Injury. Laser energy can produce bums. Adjacent structures, including the eyes, may be injured or permanently damaged by the laser beam. Burns are rare, yet represent the effect of heat produced within the tissue by laser energy. Protective eyewear will be provided to eliminate exposure when indicated.

_____Photographs. I authorize the use of any photographs taken before or after for teaching and other medical viewing purposes, with the understanding that I will not be identified.

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 questions whatsoever and give my full informed consent to have Laser Therapy performed. I further agree to follow all Laser Post Treatment Instructions.

Patient or Legal Guardian Signature:_____

Date:_____

Laser Tech/Nurse/Physician:_____

Date:_____

Patient name:_____

Treatment sites:_____

I duly authorize_____to perform the Soprano Laser Hair Removal procedure and any other measures which in their opinion may be necessary.

_____(Initial here) I understand that the Soprano is a device used for laser hair removal and that clinical results may vary in different skin types and hair types. I understand there is a possibility of short-term effects such as reddening, blistering, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me.

Clinical results may vary depending on individual factors, including medical history, align and hair type, patient compliance with pre/post treatment instructions, and individual response to treatment. I understand that epilation with the Soprano system is a safe alternative to methods used for removing unwanted hair, such as shaving, waxing, chemical epilation and electrolysis.

_____(Initial here) I understand that treatment by the Soprano laser hair removal system involves a series of treatments and the fee structure has been fully explained to me.

_____(Initial here) I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

_____(Initial here) I confirm that I am not pregnant at this time, and that I have not taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator.

_____(Initial here) I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion

_____(Initial here) I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Print your name:_____
Patient Signature:_____
Date:_____
Witness:_____