

Dermatology Associates Medical Group
Laser Center

LASER HAIR REMOVAL CONSENT FORM

I consent to have hair removal treatments with the LightSheer laser. I understand that pain, bruising, swelling, redness, blistering, hypopigmentation (lightening of the skin) or hyperpigmentation (darkening of the skin) are possible risks and/or complications to this procedure. Usually, if these occur, they are temporary and resolve in a few days or weeks. Color changes can occur in any patient, but these changes are more likely to occur in darker skinned patients. While scarring is possible, it is rare. Eye injury is possible but unlikely, providing complete eye protection is properly used throughout laser treatment sessions.

I have been informed not to “tan” 4 weeks prior to treatment, or to apply self-tanning products 2 weeks prior. Doing so can lead to permanent pigmentation changes as described above.

I understand that *multiple sessions* (4-8 weeks apart, depending on the area being treated) are necessary to achieve 80-90% reduction/clearance of the hair. Individual response will vary according to skin types, hair color, degree of tanning, follow up care, and the body area being treated. While these treatments generally produce long lasting hair reduction, some hairs may never disappear. I understand results are not guaranteed.

Hormonal areas (such as the face, neck and back) may take longer to treat. Hormonal imbalances and some medications affect hair growth and increase treatment time as well. Although uncommon, the hair removal laser has the potential to stimulate hair growth in dormant hair follicles. This hair growth induction is a treatable complication, but may require additional treatments.

I have informed the Registered Nurse if I have any tattoos/permanent make-up or an implanted device in the area to be treated. I also have listed all medications I am taking, as some medications may increase sensitivity to laser treatments. I have also informed the Registered Nurse of any history of cold sores, fever blisters, or herpes near the area to be treated, as an anti-viral medication may be necessary as part of my pre/post laser treatment. I understand the procedure, and risks, accept the risks, and request that this procedure be performed on me by qualified staff.

***Mobile number:** _____ (or best number to reach you on the *day of appointment*)

***Patient Signature:** _____ **Date:** _____

***Patient Name:** _____
(Please Print)

Witness: _____ Date: _____

Dermatology Associates Medical Group Laser Center
465 N. Roxbury Drive, Suite 801
Beverly Hills, CA 90210
310.274.9954 Ext. 227

Laser Hair Removal Patient History

Patient Name: _____ Date: _____

Allergies: _____

Please list all current medications, including oral, topical, over-the-counter, and herbal supplements:

- | | | |
|--|-----|----|
| 1. History of HSV (cold sores, fever blisters)
(If yes, patient may be given one dose of an antiviral now, and a prescription). | YES | NO |
| 2. Sun exposure in the past 2-4 weeks
(including self-tanning product). | YES | NO |
| 3. Waxing , tweezing, plucking, depilatories,
or electrolysis in the area to be treated
in the past 4-6 weeks? | YES | NO |
| 4. Use of Retin-A, glycolic acid, bleaching
cream, or prescription topical in the last
3-4 days? | YES | NO |
| 5. Current use of Antibiotics? | YES | NO |
| 6. (For female patients) Are you pregnant? | YES | NO |
| 7. Cosmetic tattoos/permanent make-up in
the area to be treated? | YES | NO |

Patient Signature: _____ **Date:** _____

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TOPICAL ANESTHETIC CONSENT

Some patients experience mild to moderate discomfort during the laser treatments. For this reason we offer the use of a topical anesthetic cream. In some instances, the cream may cause a temporary local irritation in individuals who are sensitive to the active ingredients. Although very rare, other more serious side effects can occur. People with a known sensitivity to local anesthetics (Benzocaine, Lidocaine, Tetracaine) should not use this product. If you have been diagnosed with a cardiac or liver condition, take cardiac medication, or are currently pregnant or breastfeeding you should not use this product. This product will not be applied to large surface areas or multiple body sections during a single procedure.

I am choosing to use a topical anesthetic for my laser/light treatment. I have no known allergies/sensitivity to Benzocaine, Lidocaine, or Tetracaine. I understand the potential risks and I have informed the Registered Nurse of my current medical conditions and/or medications.

Patient

Date

Witness

Date

**DERMATOLOGY ASSOCIATES MEDICAL GROUP
465 N ROXBURY DR #801
BEVERLY HILLS, CA 90210
310-274-9954 EXT. 227**

PATIENT CANCELLATION POLICY

DERMATOLOGY ASSOCIATES MEDICAL GROUP LASER CENTER HAS A 24-HOUR CANCELLATION POLICY FOR COSMETIC PROCEDURES. THESE PROCEDURES INCLUDE ALL LASER, INTENSE PULSE LIGHT AND AESTHETIC TREATMENTS.

I UNDERSTAND THAT I WILL BE CHARGED \$100.00 IN THE EVENT THAT MY COSMETIC PROCEDURE APPOINTMENT IS NOT CANCELLED 24 HOURS IN ADVANCE.

IN ORDER TO PROVIDE THE BEST POSSIBLE SERVICE TO ALL OF OUR PATIENTS, WE ASK THAT YOU ARRIVE AT YOUR SCHEDULED APPOINTMENT TIME. **LATE ARRIVALS MAY HAVE TO BE RESCHEDULED AND THE CANCELLATION FEE WILL APPLY.**

Patient: _____ Date: _____

Witness: _____ Date: _____