Illuminate Me

PATIENT CONSULTATION FORM FOR LASER HAIR REMOVAL

Client Name: _____

I hereby authorise Leanne Doré to perform laser hair removal procedure on me. I understand that this procedure works on growing hairs and not on dormant hairs. For this reason, complete destruction of all hair follicles from any treatment is unlikely, and I understand that I will require several treatments to obtain significant, long-term reduction of hair growth. I also understand some people may not experience complete hair loss even with multiple laser procedures.

The following points have been discussed with me:

- The potential benefits of the proposed procedure
- The possible alternative procedures
- The probability of success
- The reasonable anticipated consequences if then procedure is not performed.
- The most likely complications/risks involved with the proposed procedure and subsequent healing period, including but not limited to, infection, scarring, blistering and pigment changes
- Post treatment instructions

I am aware of the following possible experiences/risks with laser treatment:

- **DISCOMFORT:** Some discomfort may be experienced during the treatment.
- **WOUND HEALING:** Any laser procedure can result in swelling, blistering, crusting or flaking of the treated areas, which may require one to three weeks to heal.
- **BRUISING/SWELLING/INFECTION:** With some lasers, bruising of the treated area may occur. Additionally, there may be some swelling noted. Finally, skin infection is a possibility although rare, whenever a skin procedure is performed.
- **PIGMENT CHANGES (skin colour):** There is a slight possibility that the area treated can either be hypo pigmented(lighter) or hyper-pigmented (darker) in colour to the surrounding skin. This is usually temporary but on rare occasions it may be permanent.
- **SCARRING:** Scarring is a rare occurrence but is a possibility when the skins surface is disrupted. To minimise the chances of scarring, it is important that you follow the post-treatment instructions carefully
- **EYE-EXPOSURE:** Protective eye-wear (shields) will be provided. It is important to keep these shields on at all times during the treatment in order to protect your eyes from accidental laser exposure.

ACKNOWLEDGMENT

I understand and acknowledge that payments for the above procedure are non-refundable. By my signature below, I certify that I have read and fully understand the contents of this permission form for the treatment of laser hair removal and the disclosures referred to herein were made to me.

Signature-Patient or Guardian

Print Name/Relationship **Date**

Signature-Witness

Print Name **Date**