Consent For Laser Hair Removal:

I _____ (patient's name), authorize the technicians at SMOOTH to perform Laser Hair Reduction treatment(s) on me. There are several alternatives to laser hair removal including but not limited to electrolysis, shaving, waxing and plucking or no treatment at all.

I understand that serious complications are rare but possible. Common side effects include temporary redness, swelling and mild "sunburn" like effects that may last a few hours to 3-4 days or longer on the treated area. Other potential risks include itching, pain, bruising, burns, infection, scabbing, blistering, hypopigmentation, hyperpigmentation, scarring, and failure to achieve the desired result(s). Initial ____

I understand that a single procedure will most likely fail to completely remove all my unwanted hair on the treated area. Multiple treatments are required. Individual response will vary according to skin types, hair color, degree of tanning, follow up care, and the body area being treated.

I understand that treatment can be painful, but this is typically managed without any pain relief medication. Discomfort generated by that laser pulse is most commonly described as a rubber band snapping against the skin. Topical anesthetics are available to decrease any perceived discomfort. Color changes, such as hyperpigmentation (brown/red discoloration) or hypopigmentation (skin lightening), may occur in the treated skin. This may take several months to resolve, if at all. Unprotected sun exposure in the weeks following treatments is contraindicated as it may cause or worsen this condition. Blistering of the skin may occur. Scarring happens but is uncommon.

Lasers can cause eye injury and protective eyewear must be worn during treatment.
I understand that sun or tanning lamp exposure and not adhering to the post-care instructions provided to me may increase my chances of complications.
I understand that no refunds will be given for treatments or for treatments paid in advance.

I have read, been explained and understand as well as given the post-treatment instructions. Initial ____

_____ _____

Patient Signature Date