

McCarley Dermaspa
Betsy McCarley, MD

Laser Hair Removal Informed Consent

I understand that the purpose of this procedure is to remove unwanted hair. There are several alternatives to laser hair removal treatment including but not limited to electrolysis, shaving, waxing, plucking or no treatment at all.

I understand that the possible risks of the procedure include pain, purpura, swelling, redness, bruising, scarring, blistering, hypopigmentation, hyperpigmentation and unforeseen complications. Eye injury is possible but unlikely, providing complete eye protection is properly used throughout laser treatment sessions.

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

I understand that the treatment may be painful, but this is typically manageable without any pain relief medication. Color changes such as hyperpigmentation (brown/red discoloration) or hypopigmentation (skin lightening) may occur in 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.

I understand that every patient is different. In general, lighter skinned patients will require 3-6 treatments and darker skinned patients will require 4-8 treatments spaced approximately 6-8 weeks apart to achieve satisfactory results. Our practice cannot promise that each patient will achieve their desired level of permanent hair reduction; however, on average, most patients can expect to achieve a 50-90% reduction in the number of hairs following a full course of treatment.

_____(please initial) **I DO** give permission for photographs to be used by the physician for marketing or education-promotion purposes. Although photographs or accompanying material will not contain my name or any other identifying information. I am aware that I may or may not be identified by the photos.

OR

_____(please initial) **I DO NOT** give permission for photographs to be used by the physician for marketing or education-promotion purposes. Although photographs or accompanying material will not contain my name or any other identifying information.

Cancellation is required 24 hours prior to appointment; failure to cancel within the required time will result in a fee of \$25.00 being charged to the credit card on file. A No Show is considered failure to cancel or failure to show for a scheduled appointment, a fee of \$50.00 will be applied to the credit card on file. Current credit card information is required at the time of booking your first appointment.

I have been asked at this time whether I have any questions about this procedure and I have no further questions. I understand the procedure and risks, accept the risks and request that the doctor or doctor's assistant perform this procedure on me.

Patient:_____ Date:_____ Practitioner:_____

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