Horizons

Wellness

Informed Consent: Laser Hair Removal

Name: _____ Date: _____

I hereby authorize and direct any associate of All Care Medical Laser Center to perform laser assisted hair removal on me. I understand that this procedure works on the growing hairs and not on dormant hairs. For this reason, complete destruction of all hair Follicles from any one treatment is unlikely, and I understand that I will require several treatments to obtain a significant, long–term reduction of hair growth. I also understand some people may not experience complete hair loss even with multiple laser procedures.

I am aware of the following possible experiences/risks with the treatment of the Icon Laser Hair Removal:

___ 1. **Discomfort:** Some discomfort may be experienced during laser treatment.

___ 2. **Healing Wound:** Laser treatment can result in swelling, blistering, crusting, or flaking of the treated areas, which may require one to three weeks to heal. Once the surface has healed, it may be pink or sensitive to the sun for an additional two to four weeks or longer in some patients.

___ 3. **Scarring:** Scarring is a rare occurrence, but it is a possibility when the skin's surface is disrupted. To minimize the chances of scarring, it its important that you follow all post-treatment instructions.

___ 4. **Pigment Changes:** During the healing process, there is slight possibility that the treated area can become either lighter or darker in color compared to the surrounding skin. This is usually temporary, but on a rare occasion, it may be permanent.

___ 5. **Eye Exposure:** It is important that you keep protective goggles on at all times during treatment to protect your eyes.

___ 6. **Guarantee:** Due to the nature of this treatment an exact result cannot be predicted and I acknowledge that no guarantees have been made to me as to the results that may be obtained. I understand that payments for laser treatments are non-refundable.

___ 7. **Pre and Post Care:** I understand that it is my responsibility to follow the pre and post treatment instructions given to me and to contact the office if any complications occur.

___ 8. **Photographs:** I give permission for my photographs to be used to help document my treatment course. Complete confidentiality will be maintained.

1029 Pleasant Street | Suite 102 | Bridgewater, MA 02324
P: 508-807-0634 | F: 508-807-5283

Your consultant has explained the theory of this treatment and any risks involved, including but not limited to infection, scarring, crusting, re-growth of hair, and blistering.

My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby Horizons Health and Wellness, LLC and Horizons Wellness, LLC from all liabilities associated with the above indicated procedure.

I certify that I have read and fully understand the contents of this consent form and I authorize treatment with the Icon Laser.

_____	_____	_____
Print Name	**Patient Signature**	**Date**
_____	_____	_____
Print Name	**Witness Signature**	**Date**