FACIAL PLASTIC
SURGERY CENTER
A division of Otolaryngology Associates, PC

LASER HAIR REMOVAL CONSENT FORM

Patient_____ Date_____

1. The purpose of this treatment is to **reduce** *or* **eliminate** unwanted hair. *I understand that the results from this treatment vary with each individual.*

2. The LPIR/Apogee laser produces an intense burst of light that is absorbed by the hair follicle without causing damage to the surrounding tissue. All personnel in the treatment room, including myself, will wear protective eyewear to prevent damage from this intense light.

3. I consent to the taking of photographs during the course of my laser therapy for the purpose of medical education. These photographs may be used for teaching or publication, as the physician deems appropriate. If I do not want my photographs published, I will put it in writing.

4. The sensation of the light is uncomfortable and may feel like a pinprick or burst of heat that lasts a few seconds. The use of anesthesia is at the discretion of the physician, nevertheless, all the options and possible side effects will be discussed with me.

5. Multiple treatments will be necessary for permanent hair reduction. I have been informed that blistering, scarring, hypo-pigmentation (lightening of the skin) and hyper-pigmentation (darkening of the skin) are possible risks and complications of this procedure. **I understand that sun exposure and not adhering to post care instructions may increase my chance of complications.** The area should be treated delicately following treatment according to post treatment instructions given me by my laser technician.

I certify that I have read and understood all information presented to me before signing this consent form. I have also been given the opportunity to ask questions. Therefore, I authorize LPIR laser hair removal therapy to be performed.

Patient_____ Date_____
(or legal guardian)

Witness_____ Date_____