

Date: _____

Name: _____

Date of Birth: _____

Please initial and sign below:

- _____ I commit to 6 consecutive minimum treatments for optimal results.
- _____ The goal of this treatment is improvement and not perfection. I understand there will be some hair left at the end of my treatments. The amount of hair that remains will be relative to the fluency (energy).
- _____ Average loss at the end of consecutive sessions is 70-95% less hair. The amount of loss cannot be determined until after the second or third treatment.
- _____ There may be more treatments necessary than I anticipated. The typical number is 6 to 8 or more for darker skin types.
- _____ Laser / Light Assisted removal / reduction in studies has shown to reduce hair permanently but results can vary from person to person.
- _____ I agree to pay the fee quoted and understand that all fees quoted are non-refundable.
- _____ I agree to have clinical photos taken of the area to be treated.
- _____ Only with written permission will my photos be used for public display.

Studies and experience with this technology have shown these to be some potential complications and side effects:

- _____ - 10-20% chance of developing hypo- and/or hyper-pigmentation, usually temporary
- _____ - purpura, chance of developing blistering, crusting, bruising.
- _____ - freckles and brown spots may linger and disappear
- _____ - pimples, redness and swelling
- _____ - purple mottling discoloration can occur with hair removal on legs
- _____ - new reports are documenting the incidence of increased growth of facial hair on females especially in the neck and it may not resolve with further treatments

- _____ I understand that if I have a history of cold sores or genital herpes I may require pre and post treatment with anti viral medications.
- _____ I understand that I am responsible to provide my own Emla™, (Topical anaesthetic cream).
- _____ I agree that I have not tweezed, waxed, threaded or had electrolysis for the past 4 weeks.
- _____ I agree not to tan while undergoing Laser hair reduction treatments. I agree to protect my skin with a minimum of a SPF30 4 weeks prior to and during my entire treatment course.
- _____ I understand that my medication _____ which is known to be photosensitizing increases my chance of developing blisters, I am willing to accept that risk.
- _____ I understand that to have the best result possible I have to agree to the treatment the Service Provider discussed with me.
- _____ I agree to follow post care instructions.

By signing below I acknowledge that the treatment process thoroughly explained to me. I understand the potential benefits and complications and willingly agree to undergo Laser / Light Assisted Hair Reduction treatments to reduce my body hair.

Print Name of Client

Signature of Client

Date

Print Name of Service Provider

Signature of Service Provider

Date

2: _____ 3: _____ 4: _____ 5: _____ 6: _____

I have reread this consent prior to my next treatment and agree that there have no changes in my health or medical condition. I acknowledge that I understand the statements in this consent.