



**Laser Hair Removal  
Informed Consent Form**

**Please, read carefully and initial next to each statement:**

- \_\_\_\_\_ I am not pregnant, nursing, or trying to become pregnant.
- \_\_\_\_\_ I have stopped use and been off of all antibiotics, or any other drug that may cause photosensitivity, for at least 7 days.
- \_\_\_\_\_ I have not used Accutane or any other isotretinoin medication in the past 6 months.
- \_\_\_\_\_ I have not used self tanner in the area to be treated in the past 7 days.
- \_\_\_\_\_ I have not received electrolysis, tweezed, waxed, threaded, or removed hair from the follicle any method other than shaving in the past 3-4 weeks.
- \_\_\_\_\_ I am aware if I have herpes simplex virus 1 or 2, I need to be on an oral antiviral medication at least 2-3 days prior to laser treatment.
- \_\_\_\_\_ Laser hair removal produces an intense burst of light and light energy to selectively heat, remove, and/or reduce hair without harming the surrounding tissue.
- \_\_\_\_\_ For best results, I have been informed multiple treatments will be necessary.
- \_\_\_\_\_ For best results, I understand laser hair removal treatments need to be scheduled consecutively and it is recommended they are scheduled 4-6 weeks apart depending on the area being treated.
- \_\_\_\_\_ I understand laser hair removal is based on the principles of selective photothermolysis; and, it is a combination of the appropriate laser wavelength, pulse duration, and fluence. Not all laser hair removal devices use the same wavelengths, pulses, and/or fluence.
- \_\_\_\_\_ I understand that all lasers and/or laser hair removal devices are not the same and, if I have had laser hair removal treatments somewhere else or do so in the future, the laser treatment I received may not be the same as the laser treatment I will receive at Gardner Dermatology & Med Spa.
- \_\_\_\_\_ I understand complete removal and/or clearing of my hair may not be possible.
- \_\_\_\_\_ I understand maintenance may be needed after my initial series of treatments; and, new hair growth may occur in the treated area. This new hair growth may be caused by various factors including age, hormones, and/or new medications.

\_\_\_\_\_ I have been understand the risks and complications that may be associated with this procedure. I have been informed the risks and complications may include, but are not limited to:

- Bruising and purpura (red-purple discoloration)
- Bleeding
- Infection
- Hyperpigmentation (darkening of the skin) and may be permanent
- Hypopigmentation (lightening of the skin) and may be permanent
- Itching or a hive-like response
- Burns, blisters, textural changing or scarring
- Swelling, redness and/or discomfort

\_\_\_\_\_ I am aware this procedure may activate individual sensitivities. These sensitivities may include, but are not limited to: herpes simplex virus, which can cause cold sores and fever blisters, hirsutism (increased hair growth), an/or lymphadenopathy (enlarged lymph nodes).

\_\_\_\_\_ After laser treatment, redness, swelling, welting, itching, dry skin and/or discomfort may occur. I understand these complications typically resolve within a few hours, days, weeks, or months; however, some complications such as scarring, hyperpigmentation, and/or hypopigmentation may be permanent.

\_\_\_\_\_ I understand any redness, swelling, and/or discomfort usually resolves within several hours, but may last for 2-3 days. The treated area may feel like a sunburn or windburn (minor discomfort) for a few hours after treatment. Discomfort may be treated with the application of cool compresses, antibiotic ointment, Aquaphor, and/or topical soothing agents.

\_\_\_\_\_ I am aware I will be given aftercare instructions regarding care of the treated area(s). I understand it is important to follow all aftercare instructions carefully to minimize the risks of incomplete healing, scarring, and/or skin textural changes.

\_\_\_\_\_ I am aware that there are other methods of treatment available for hair removal and have assessed the risks and benefits of laser hair removal and these alternative methods.

\_\_\_\_\_ Anesthesia is usually not necessary for this procedure. My provider and I may elect to use a form of anesthesia to reduce my discomfort during the procedure. A cryogen spray skin cooling device may be used during the procedure to decrease discomfort and protect the skin.

\_\_\_\_\_ I understand I need to avoid direct sunlight, because sun sensitivity of the treated area may remain for several weeks after a laser treatment.

\_\_\_\_\_ I understand I need to protect my skin from the sun and I need to use a broad spectrum UVA/UVB protective sunscreen in order to reduce the risk of damage to the skin. I understand I must wear a broad spectrum UVA/UVB protective sunscreen during instances where I am exposed to sunlight. These instances include, but are not limited to:

- sitting in the car
- walking to the mailbox
- sitting next to a window to reduce the risk of damage to the skin.

\_\_\_\_\_ I understand my skin may be sensitive for a week or more after laser treatment and I should avoid using extremely hot water and skin care products that may cause irritation. These skin care products may include, but are not limited to: scrubs, toners, retinoids, glycolic acids, anti-aging ingredients, and/or acne products.

\_\_\_\_\_ I understand hair growth occurs in three different cycles and the hair must be in the Anagen phase of growth in order for laser hair removal to work. The duration of hair cycle and percentage of hair in the Anagen (growth) phase is different for all areas of the body. I also understand the depth of the hair follicle varies throughout the body. Age, ethnicity, metabolism, medications, and changes in hormones affect the location, resilience, and thickness of hair. I understand these factors influence the success of laser treatments, why multiple treatments are needed and, why we are unable to predict the number of treatments each individual will need to be satisfied with the results.

\_\_\_\_\_ I understand laser hair removal is a cosmetic procedure that is elective and is not covered by insurance.

\_\_\_\_\_ I understand, recognize, and acknowledge Dr. Alan M. Gardner, the laser technicians, estheticians and/or any other staff members of Gardner Dermatology & Med Spa have made no guarantees to me concerning the results of my laser treatments.

\_\_\_\_\_ I have provided my past and current medical history and medications.

\_\_\_\_\_ Contraindications of this procedure have been discussed in detail with me.

\_\_\_\_\_ I have read and understand all information presented to me concerning this procedure before signing this consent form.

\_\_\_\_\_ Questions I have about the risks, benefits, and results pertaining to this procedure have been answered and discussed to my satisfaction.

Patient Name (printed): \_\_\_\_\_

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Staff/Witness Signature: \_\_\_\_\_

Date: \_\_\_\_\_