INTERLOCKS™
MEDSPA + WELLNESS

INFORMED CONSENT FOR LASER HAIR REMOVAL

Patient Name: _____ Technician: _____

Treatment site(s): _____

The purpose of this procedure is to diminish or remove unwanted hair. The procedure requires more than one treatment and may produce permanent hair removal. The total number of treatments will vary between individuals. On occasions there are patients that do not respond to treatments. The treated hair should exfoliate or push out in approximately 2-3 weeks.

The following problems may occur:

1. Some discomfort and/or pain may be experienced during treatment.
2. Short-term effects may include reddening, mild burning, temporary bruising, blistering or bleeding.
3. During the healing process, there is a slight possibility that the treated area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color, compared to the surrounding skin. This is usually temporary, but, on rare occasions, it may be permanent. Avoiding sun exposure before and after treatment reduces risk of color changes.
4. Sun exposure may increase risk of side effects and adverse effects.
5. Infection is a possibility whenever the skin surface is disrupted, although proper wound care should prevent this. Herpes simplex virus blisters around the mouth can occur following a treatment for both individuals with a past history of herpes simplex virus and individuals with no known history of herpes simplex virus. Should any type of skin infection occur, additional treatments or medical antibiotics might be necessary.
6. Paradoxical hair growth (the stimulation of terminal hair growth) or leukotrichia (temporary or permanent gray hair) can occur within or adjacent to treated area.
7. Allergic reactions. In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations have been reported. Systemic reactions may result from prescription medications.
8. Protective eyewear (shields) will be provided to you during the treatment. Failure to wear eye shields during the entire treatment may cause severe and permanent eye damage.

Compliance with the aftercare guidelines is crucial for healing, prevention of scarring and hyperpigmentation.

ACKNOWLEDGEMENT:

I acknowledge that the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me
- Alternative treatments such as electrolysis, waxing, plucking and depilatories
- Reasonable anticipated health consequences if the procedure is not performed
- Possible complications/risks involved with the proposed procedure and subsequent healing period

For women of childbearing age: By signing below, I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep Technician informed should I become pregnant during the course of treatment.

I hereby authorize above named Technician to perform light based hair reduction on me. I understand that this procedure works on the growing hairs (anagen) and not on dormant hairs. I understand that I will require several treatments to obtain a significant, long-term reduction of hair growth. I understand I may experience fewer, thinner, lighter, slower re-growth of hairs, temporary hair loss or permanent hair reduction. I understand that it is only effective on hair with color and does not treat white, grey, blonde or red hair. I understand that genetics, hormones, medication and hair color may interfere with hair loss and that I may not respond at all. My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release INTERLOCKS from all liabilities associated with the above indicated procedure.

Patient/Guardian Printed Name: _____ Date: _____ /_____ /_____

Patient/Guardian Signature: _____ Date: _____ /_____ /_____

Laser Technician Signature: _____ Date: _____ /_____ /_____