



LASER HAIR REMOVAL CONSENT FORM

The Laser Hair Removal procedure has been thoroughly explained. I realize that no promises or guarantees have been made. I understand that the treatment may be repeated several times to achieve complete satisfaction. I understand that this treatment is voluntary on my part. My signature below indicates that I have agreed to receive the Laser Hair Removal Treatments as prescribed by Golla Center for Plastic Surgery.

Golla Center for Plastic Surgery offers the most advanced approach to laser hair removal available today. Because the scanner is software controlled, the laser wavelength, intensity and exposure time is precisely measured to prevent any tissue damage. Individual hair follicles are destroyed only during the growth phase, so multiple treatments may be required

I understand the procedure will include:

- Hair at the treatment site(s) will be shaved
- Application of an anesthetizing cream to the treatment area. I will wait 25 minutes for the cream to take effect
- A laser using a predetermined energy dose will treat the area(s)
- A light coating of Cortisone and ice packs may be applied to the site(s) after treatment
- The time of the treatment will be 30-60 minutes based on the treatment area(s)

I have been given the following information:

- I may experience pain, burning, blistering or stinging sensations at the site(s)
- If any of the above occurs, there may be chance of infection at the site
- There may be some change in color of the pigment in the site area
- There is a possibility of scarring in the site area

I certify that I have read this entire consent and that I understand and agree to the information provided in this form. I certify that I am a competent adult at least 18 years of age. I understand that if I am a minor under the age of 18, the consent of my parent or legal guardian will be required before treatment. This consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns.

I authorize taking of pictures before and after the injections. I consent to their use for instructional, scientific, and educational and research purposes. However, these photographs will not identify me by name and my name will not be revealed without my specific written consent.

I acknowledge that I am obligated to follow Golla Center for Plastic Surgery instructions closely and visit the office as directed. I have been given ample opportunity for discussion and my questions have been answered to my satisfaction. I understand this treatment includes payment and the fee structure has been explained. I have received no medication before signing this consent form

I agree to pay \$_____ for the first treatment, and \$_____ for each treatment thereafter; or \$_____ for a ____ visit treatment package.

Signature: _____ **Date** _____

Guardian Signature: _____

Staff Signature: _____