Laser Hair Removal Consent Form

In signing this document, I, _____, give permission for Body Fountain to perform laser hair removal.

I understand that the goal of this procedure is the gradual permanent reduction of my hair. I understand that every individual is unique, and it is very difficult to guarantee a specific number of treatments needed. It is expected that I will require four to six treatments for the body and six to eight treatments for the face, give or take one treatment. _____ initials

I agree to call the clinic if I have any difficulty after my treatment. The number to call is:708-408-1771 _____ initials

I acknowledge that I have not waxed the treated area within the previous six weeks nor have I plucked the hair from the area being treated. I acknowledge that I have not been sun tanning for the previous FOUR weeks. _____ initials

Although uncommon, I understand that complications can occur. It has been explained to me that these complications include: a sunburn feeling, redness, local tenderness and mild swelling, occasionally blistering, very rarely pigmentation changes and scarring. _____ initials

I understand that how I take care of my skin after treatment influences my risk of complications. I agree to wash my skin gently twice-daily and apply an antibacterial cream for the first week. I agree to stay out of the sun or to use sufficient sun block for FOUR weeks following my treatment. I agree to call the clinic if I develop any markings on my skin after treatment, and I will not pick at them. _____initials

I have not taken Accutane within the last 12 months. _____ initials

I am not currently pregnant. _____ initials

I am not allergic to topical anesthetics (topical freezing). _____ initials

If I have forgotten to tell the clinic staff of my health problems, medications, allergies, or other important information about me, I will do so now. I will inform Body Fountain if I become pregnant. _____ initials

I hereby give my permission to undergo laser hair removal.

Patient Name: _____

Patient Signature:_____ Date:_____