Consent and Release for Laser Hair Removal

Please read carefully and initial each line before signing the bottom of this agreement. If you have any questions, please ask for further details or clarification.

I _____ authorize a laser technician(s) from Capital Laser to perform laser hair removal using lasers on my body.

_____ I understand that laser procedure is purely elective; I undergo this procedure solely at my request. I understand that response to treatment varies on an individual basis and the specific results are not guaranteed. I understand that there is no guarantee, warranty, or assurance with this procedure and that hair may regrow for known or unknown reasons and conditions.

_____ I understand that the procedure is permanent hair reduction and that several treatments may be needed to obtain permanent hair reduction (per FDA standards). I understand it is difficult to predict the effects of the procedure.

_____ I have been informed and understand that lasers used in this procedure can cause eye injury and therefore I must wear protective eyewear and keep my eyes closed during this procedure.

_____ The laser technician will determine the appropriate energy dose to be used. A light coating of Vaseline, aloe gel, or ultrasound gel, and ice packs may be applied to the site(s) during and/or after treatment.

_____ I consent to having photo(s) taken of the treatment area(s). I understand that only part of my face will be shown when taking facial pictures. The photos may be used at the discretion of the laser center for research and/or future comparisons. I understand that my picture may be shown for educational purposes and my name will remain anonymous.

_____ The topical anesthetic cream and/or zimmer to cool the skin may be used as necessary to reduce potential pain during the procedure. If you have sensitivity to amide-type anesthetics, please inform the technician before the procedure takes place

_____ I understand that immediately following laser treatment, the treatment area may appear red, discolored, and/or show signs of swelling. The swelling lasts two (2) or more hours. The treated area may feel similar to sunburn for a few hours after treatment. During this period use either an antibiotic ointment (Neosporin), (Hydrocortisone 2%) or aloe vera gel. Although rare, I may have a skin reaction/breakout within the two to three weeks after treatment when the treated hairs are shed from the skin.

_____ I have been informed and understand that there are discomforts and some potential serious complications that may accompany this procedure including: pain, burning, stinging sensation at the site of treatment, infection associated with the treatment site, scarring, blistering, bruising (prupura), white spots (hypo-pigmentation) or dark spots (hyper-pigmentation). Typically, the discoloration lasts a few weeks to several months. Usually, the aforementioned complications are temporary and resolve themselves in a few days, weeks, or months, depending on skin type. Certain drugs may cause increased redness, blistering, mild burning, and itching at the treatment site. If I have any questions or symptoms after the procedure, I will contact the laser center.

Please continue on the reverse side

*Optional

_____ I understand that if I have any changes in my medical history or start any medication, I must inform the laser technician prior to treatment. I acknowledge that I am not pregnant nor am I currently breastfeeding at the present time.

_____ Currently I am not taking any antibiotics. I have been informed that the use of antibiotics is linked to photosensitivity, which can cause the skin to have adverse reactions to the laser.

_____ I have been informed and understand that before, during, and at least (4) weeks after my treatments have been completed, I must wear sunscreen with at least SPF 30 or higher to protect my skin and I should avoid sun exposure.

_____ I understand that there will be a charge for this and all consecutive treatments. I understand that if I do not use all sessions in my pre-paid package within 15 months, I forfeit the balance. I understand that with some promotions I receive one or more session(s) free and that free sessions have no cash or transfer value. All balances are due prior to treatment. Gift certificates are not redeemable for cash.

_____ **I understand and agree to a 20% processing fee of the total purchase price in the event of cancellation. Additionally, any service that has been rendered will be fully deducted from the regular price regardless of any promotions received. I understand that failure to show for an appointment with less than a 48-hour notice or showing up late for an appointment will result in a $50 penalty.**

_____ I am aware that blonde, white (gray), and some shades of red hair are not targeted by the laser and that fine (thin) hairs, in some cases female facial and neck hair, are more difficult to eliminate than coarse hairs. Facial hairs are more prone to this, due to known and unknown conditions.

_____ I have received the *Before and Aftercare Instructions* and I understand them. I will comply with the recommended before and aftercare guidelines and understand they are crucial for optimal results, healing, prevention of scarring and hyper/hypo pigmentation.

_____ The risks and benefits of the GentleMax Pro and/or Clarity II laser procedures have been explained to me. I understand that I am making a decision to undergo the procedure described in the preceding sections subject to the conditions of my participation described above. My signature indicates that I have decided to receive the treatment, having read, and understood the information presented above and having been given the opportunity to ask any questions that I might have about the procedure.

_____ I agree to forever hold Capital Laser harmless and release from any and all liability, claims, or demands of any kind or nature related to the transmission of any disease, condition or illness they may allege to have contracted or been exposed to as the result of any treatment, person, or visit at the insured's location. I release Capital Laser, medical director, nurse and laser technicians, as well as any officers, directors, or employees of the above companies for any condition or result, known or unknown, that may arise as a consequence of any treatment I receive.

Signed:_____.Date:_____.

Witness:_____.Date:_____.