Evergreen LASER
Laser Hair Removal & Med Spa

Laser Hair Reduction Consent Form

Patient Name:_____ Date:_____
(First) (Last)

This form provides detailed information regarding Laser Hair Reduction (hereinafter the "Treatment"). Please read this form thoroughly and make sure all your questions are answered before deciding to undergo treatment. After reading this document, **please initial each section**, and date the appropriate areas.

x _____ Treatment: Laser treatment reduces unwanted hair by exposure to laser light. I understand that this Treatment is entirely voluntary and that the results may be unpredictable. Results vary from person to person and may even vary in different areas on the same person. Multiple treatments are necessary to achieve desired results, and the number of Treatments recommended during my consultation is only an estimate. I also understand that the Treatment is, in most cases, effective, but there is no guarantee that the expected or anticipated results will be achieved.

x _____ Hair Treatment Results and "Maintenance Treatments": I understand that complete hair removal is not likely but that with multiple treatments, a significant long-term reduction can be achieved. I understand that the goal of my treatment is a reduction in hair, not perfection. I acknowledge that a hair reduction of 70% is an excellent (but not guaranteed) outcome. I also understand that thinner, finer, "patchy," sparse, and/or less dense hair may be the result. Some hair will never completely disappear; a no hair reduction device offers 100% hair removal. I also understand that not being treated consistently may in incomplete hair reduction. I understand that additional "maintenance treatments" may be needed in the future even if excellent results have been achieved and no guarantee can be made as to the final results.

x _____ Hair Types and Areas: I understand that some types of hair (like white, grey, blonde, red, fine, "peach fuzz," and others) will not respond to treatment, and some hair (very course and thick) may not respond to treatment. I also understand that in some cases, hair in certain areas (specifically facial hair, sideburns, or neck hair [on both men and women], back hair, and other areas) may not resolve completely or may be more resistant to treatment. Rarely, unwanted hair growth (paradoxical hypertrichosis) can occur after the treatment. This is more common on the face and neck areas. The treatment for paradoxical hypertrichosis is continued hair reduction treatment.

x _____ Ancestral Background: I understand that genetics play a role and that I may need more treatments than originally anticipated depending on my ancestral background and national origin. Middle Eastern, Mediterranean, Asian, Indian, South Asian, and African American patients (and others) may need more treatments than initially anticipated and may need more "touch-up" or "maintenance treatments."

x _____ Hormones: I understand that hormonal changes (puberty, menopause, post-pregnancy, menstrual hormones, male hormones, etc.) may make hair reduction more challenging and that I may need more treatments based on my hormonal status and gender.

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x _ _ _____ Pre-Care and After-Care: I understand pre-care and after-care are entirely in my control. Failure to follow the provided pre-care and after-care guidelines will increase the chance of complications and adverse side effects and decrease the effectiveness of the Treatment. I acknowledge that I have been (or will be given) detailed oral and printed care instructions. If I have any questions about pre-care or after-care, I can contact the office. I agree to follow all of the pre-care and after-care instructions.

x _____ Adverse Side Effects & Risk: I understand that adverse side effects occasionally occur and that serious complications are rare but possible. Negative side effects may last many months, years, or even be permanent. I also understand that additional medical treatment may be necessary should I experience any adverse side effects. Evergreen Laser & Med Spa will not cover any cost associated with adverse side effects. I also understand that I may miss work or social obligations due to adverse side effects resulting from the treatment. All of the following negative side effects, risks, experiences, and complications are possible but not limited to the following.

x _____ Prolonged Healing / Itching / Hives / Sun Sensitivity: I fully understand that the treatment may result in prolonged healing (redness, spider veins, tenderness, pain, etc.) in the treated area and surrounding areas. The time it takes for these side effects to subside and for the site to heal fully may be significant. I understand that after the Treatment, I may experience itching/hives and be sensitive to sun exposure.

x _____ Burns: I fully understand that the Treatment may occasionally cause burns. Most burns are usually superficial, temporary, and heal relatively quickly. On rare occasions, these burns may be more profound or more severe and cause permanent skin changes, including but not limited to ulcers, erosions, skin discoloration, tissue texture changes, prolonged healing, sun sensitivity, and scarring.

x _____ Skin discoloration: I: I fully understand that temporary and permanent skin discoloration (undesired pigmentary alteration) includes darker skin (hyperpigmentation), lighter skin (hypopigmentation), white skin (depigmentation), or erythema (pinkness/redness/spider veins) may result from the Treatment. I understand that tan skin, sun-damaged skin, skin treated with artificial tanning products, and patients with darker skin types have a much higher rate of complications and adverse side effects, specifically skin discoloration. Thus, I understand that there is a genuine risk of skin discoloration (undesired pigmentary alteration) from the Treatment. I request to be treated, knowing that my skin may temporarily or permanently change color due to the Treatment.

x _____ I have been sufficiently informed of the Treatment's possible outcomes, risks, and side effects.

x _____ I agree to follow all pre-care instructions and after-care instructions and keep my appointments.

My initials above and signature below acknowledge that the above information has been carefully read and fully understood by me and authorizes Evergreen Laser & Med Spa and its employees (collectively and at this moment known as "Evergreen Laser & Med Spa") to perform, implement, and/or assist in the laser treatment procedure I have elected to undergo. I agree that this Informed Consent shall be effective for the first Treatment and for any and all subsequent Treatments I receive in the future. I acknowledge that this form constitutes full disclosure but may be supplemented by other verbal and/or written disclosures that I completed on "today's date," stated on pages one of two on this consent form. I am aware that it is my responsibility to inform the technician, esthetician, therapist, doctor, or nurse of my current medical or health conditions and update my records. Recent medical history is essential for the caregiver to execute appropriate treatment procedures.

PRINTED NAME OF PATIENT (FIRST, LAST)

SIGNATURE (or signature of legal guardian if patient is under 18)