TOUCH OF CLASS
MEDSPA & LASER CENTER

Laser Hair Removal Consent Form

Patient Name: ____

I understand that the purpose of this procedure is to remove unwanted hair. There are several alternatives to laser hair removal treatment including but not limited to electrolysis, shaving, waxing and plucking or no treatment at all.

I understand that the possible risks of the procedure include pain, purpura, swelling, redness, bruising, scarring, blistering, hypopigmentation, hyperpigmentation, mottling of skin vascularity and pigmentation and unforeseen complications. Eye injury is possible but unlikely, providing complete eye protection is properly used throughout laser treatment sessions.

I understand that a single procedure will most likely fail to completely remove all my unwanted hair in the area treated. Multiple treatments are required. Individual response will vary according to skin types, hair color, degree of tanning, follow up care, and the body area being treated.

I understand the treatment may be painful, but this is typically manageable without any pain relief medication. Color changes, such as hyperpigmentation (brown/red discoloration) or hypopigmentation (skin lightening), may occur in treated skin. This may take several months to resolve, if at all. Unprotected sun exposure in the weeks following treatments is contraindicated as it may cause or worsen this condition. Blistering of the skin may occur. Scarring happens but is uncommon. ➡ ________initials

I further ☐ agree ☐ do not agree that any pictures or videotape taken of me may be used for either teaching or publication, if considered appropriate; unless I notify the doctor in writing that he or she is not to use these photographs prior to publication. ➡ ________initials

I understand that the doctor is not an agent of Lumenis Inc., and that Lumenis Inc., is not an agent of the doctor for the purposes of the procedure or treatment. I hereby hold Touch of Class Medspa and Laser Center, Lumenis Inc. and any of its affiliates, harmless of any errors and omissions of the doctor in connection with the procedure or treatment using the Lumenis Lightsheer Duet Laser.

I have been asked at this time whether I have any questions about this procedure and I do not. I understand the procedure, and risks, accept the risks, and request that this procedure be performed on me by the doctor, nurse or other qualified staff.

Signature of Patient ________________________________ Date ____________________

Signature of Laser Technician ________________________________ Date ____________________

Signature of Parent/Guardian ________________________________ Date ____________________
*if under 18 years old

Lumenis, Inc.