CONSENT FORM FOR LASER HAIR REDUCTION

Clinic Name: _____ **Date:** _____
Doctor Name: _____
Patient Name: _____

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1. **PROCEDURE DESCRIPTION:**
   I, the undersigned, voluntarily consent to undergo a Laser Hair Reduction procedure. This treatment uses laser energy to target hair follicles, reducing hair growth over multiple sessions. The procedure aims to achieve long-term hair reduction but does not guarantee permanent hair removal.

2. **POTENTIAL RISKS & COMPLICATIONS:**
   I understand that while Laser Hair Reduction is generally safe, there are potential risks and side effects, including but not limited to:

   - Temporary redness, swelling, or irritation at the treatment site
   - Skin sensitivity, discomfort, or mild pain during the procedure
   - Changes in skin pigmentation (hyperpigmentation or hypopigmentation)
   - Rare risk of burns, blisters, or scarring
   - Temporary or permanent hair loss in unintended areas
   - Incomplete or variable results based on hair and skin type

3. **CONTRAINDICATIONS:**
   I confirm that I have disclosed any medical conditions that may affect the outcome of the procedure, including but not limited to:
   - Active skin infections, open wounds, or cold sores
   - Pregnancy or breastfeeding
   - History of keloid scars
   - Use of medications that cause photosensitivity, such as certain antibiotics, Accutane (Isotretinoin), or retinoids
   - History of keloid scarring or abnormal wound healing
   - Recent waxing, threading, or plucking of hair (must wait 4-6 weeks before laser treatment)
   - Recent use of Accutane or other strong medications
   - History of seizures or epilepsy triggered by light exposure

4. **ALTERNATIVE TREATMENTS:**
   I have been informed of alternative hair removal methods, including shaving, waxing, electrolysis, and depilatory creams, and understand that I have the option to decline treatment.

5. **POST-PROCEDURE CARE & FOLLOW-UP:**
   I understand the importance of following post-procedure care instructions, including

- Avoid sun exposure and use a broad-spectrum sunscreen daily
- Refraining from hot showers, saunas, or excessive sweating for 24-48 hours
- Not waxing, plucking, or threading between sessions
- Applying soothing creams or cold compresses if mild irritation occurs
- Attending all recommended follow-up sessions for best results

6. **CONSENT TO PHOTOGRAPHY (Optional):**
   I give permission for my photographs to be taken for medical records and treatment monitoring purposes. These images will remain confidential.
   [ ] Yes, I consent
   [ ] No, I do not consent

7. **INFORMED CONSENT & ACKNOWLEDGEMENT:**
   I have read and fully understand the information provided in this consent form. I have had the opportunity to ask questions, which have been answered to my satisfaction. By signing below, I acknowledge that I am making an informed decision to undergo this procedure.

Patient Signature: _____ **Doctor Signature:** _____

Date: _____ **Date:** _____

Witness (if applicable): _____

Date: _____