



## Patient Consent

I authorize United Hospital System to perform laser hair laser therapy utilizing the Candela GentleLASE Laser on me.

I have been informed that laser hair removal is a procedure by which body hair can be reduced or removed utilizing the Candela GentleLase Laser. Laser hair removal involves matching laser light and pulse duration to the follicle size, depth and location, inhibiting the re-growth of the removed hair. When performing laser hair removal, the physician/technician distributes the light beam of an Alexandrite Long Pulse Laser (755 nm) onto the skin, disabling the hairs that are in their active growth cycles at the time of treatment. I understand that I will have to wear protective opaque eyeglasses during the treatment to protect my eyes from the laser's light.

I am aware that the laser treatment can produce, but is not limited to, the following common side effects: redness, swelling, welting, itching, tingling and dry skin. I understand these side effects may last from 2 hours to several days.

I understand there are possible risks and complications that can occur from a laser treatment that could interrupt my daily life, work routine, or social life. These may include but are not limited to: burning, scab formation, heat rash, bruising, scarring, infection, hypopigmentation, and, or, hyperpigmentation. If any of these were to occur, I understand our affiliate physician is available to see me and provide post treatment guidelines to speed recovery time. If I choose to consult my own physician or seek any other medical attention, it is at my own expense.

For best results, I have been informed that multiple treatments will be needed. For most skin areas, 4-6 treatments throughout a normal hair growth cycle are necessary to achieve desired hair removal. I understand that more than 6 treatments may be needed depending on hair type, previous methods of removal, hair and skin color. I understand results are not guaranteed. Some of the factors that could trigger new hair growth are hormonal imbalance, pregnancy, medications, menopause, tweezing or waxing.

I understand that tanning during the course of my laser treatments is not recommended and can cause a number of complications. I understand that I should avoid direct sun exposure for 2 weeks after my laser treatment, which also includes tanning beds and the use of sunless tanning creams. I have been informed to use a sunscreen with an SPF of 30 or higher on treated areas during the course of my laser treatment. I understand it is my responsibility to inform United Hospital System if my skin appears any darker than when treatment first started.

I understand post-treatment care is very important after my treatment(s) and I will adhere to all instructions given to me. I understand that improper care of the treated area may increase the chances of any complications.

I have read and understood all information presented to me before signing this consent and have had ample opportunity to ask questions regarding laser hair reduction, side effects and after care. I also understand it is my responsibility to inform United Hospital System of any medical or prescription changes.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
(Patient or person legally authorized to consent for patient)

Witness \_\_\_\_\_ Date \_\_\_\_\_