pelle
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Informed Consent for Laser Hair Removal

Full Name _____Age _____ Date _____

The purpose of the procedure is permanent hair reduction. The procedure requires a series of treatments to produce a desired result. The total number of treatments will vary between individuals. On occasion, there are individuals that do not respond to this treatment. There must be an adequate amount of pigmentation in the hair follicle for the energy to be absorbed and result in the death of the hair follicle. Therefore, blonde, white, grey, red, or very light hair will not respond to this treatment.

The following may or may not occur:

1. The treated area may be red, hot or have a burning sensation, bruising, or blister. These are temporary and usually subside within hours to days, or in rare instances weeks.

2. Hyperpigmentation (darkening of the skin) and hypopigmentation (lightening of the skin) are possible complications. Pigmentation changes usually resolve with 6 months, but permanent pigmentation change is possible. Avoiding sun-exposure before and after treatment will reduce these risks.

3. Other rare complications include: Bleeding, infection, scarring, or allergic reaction.

4. I understand that sun exposure and not following post treatment instructions may increase my chances of complications. A broad spectrum sun protection with a minimum SPF 30 is to be used daily during the entire duration of treatments.

5. I understand that in order to have the best results, I must adhere to the scheduled appointments. In order for the treatment to be successful, the hair must be in its active growth phase and therefore treatment must be done in specific time frames. There are some hair follicles that are dormant and growth may be stimulated at a later date due to hormonal changes, medications, and stress levels. Therefore, touch up treatments may be needed.

6. I will wear the protective eyewear provided at all times to prevent damage to my eyes.

7. I will notify the technician immediately if I experience any other complications not noted.

Occasionally, unforeseen mechanical problems may occur with our machine and your appointment may need to be rescheduled. We will make every effort to notify you prior to your arrival. Please be understanding if we cause you any inconvenience.

☐ My questions have been fully answered and I have read or have had read to me this document, have not taken any medications which may impair my mental ability, do not feel rushed or under pressure and understand its contents. I hereby give my unrestricted informed consent for the procedure.

☐ I understand that cancellations must be made prior to appointments. I understand I must cancel 24 hours prior to my scheduled appointment or I will be charged $25.00 for every missed appointment.

☐ I give permission for photographs taken of all treated sites to be used for the medical record, and anonymously for teaching, illustration in scientific papers or for marketing and/or literature.

☐ I agree to follow up at recommended intervals to assess my status and to inform Pelle Spa, LLC of any problems that I may be having and allow examination at that time.

☐ I have been given and have read and understand the pre- and post-care instructions

☐ I am aware that it is my responsibility to inform Pelle Spa providers of my current medical conditions. I agree to abide by the above policy statements. I understand that, as with any cosmetic procedure, individual results may vary and that NO refunds will be given. I understand that if I am dissatisfied with the results of the services rendered that I am not entitled to a refund. I understand that as a valued customer of Pelle Spa, that I may contact them to determine if there is a remedy for my dissatisfaction. If I choose not to allow Pelle Spa to remedy the issue, or if i choose to allow Pelle Spa to remedy and I am still dissatisfied, that I am not entitled to a refund. I hereby release the technician performing the procedure, Pelle Laser Spa, LLC and Annette Randlemon, CNP from all liabilities associated with any and all of the above indicated procedures.

Signature

_____ Date _____

Signature of Parent/Guardian (if patient is under 18)

_____ Date _____

Provider Name and Signature

_____ Date _____

*This consent is good for one year.