**CCS Laser Rejuvenation**

**210 Jones Road, Suite 6, Falmouth MA 02540**

**PATIENT INFORMED CONSENT FORM**

FOR LASER AND LIGHT-BASED HAIR REDUCTION

I hereby authorize Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ or \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ under Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_’s supervision understand to perform light based hair reduction on me. I understand that this procedure works on the growing hairs (anagen) and not on dormant hairs. I that I will require several treatments to obtain a significant, long-term reduction of hair growth. I understand that I may experience fewer, thinner, lighter, slower regrowth of hairs, temporary hair loss or permanent hair reduction. I understand that it is only effective on hair with color and does not treat white, grey, blond, or light red hair. I understand that genetics, hormones, medication, and hair color may interfere with hair loss and that I may not respond at all.

This procedure may result in the following adverse effects or risks:

* DISCOMFORT/PAIN- Some discomfort and/or pain may be experienced during treatment.
* REDNESS/SWELLING/BRUISING- Short term redness (erythema) or swelling (edema) of the treated area is common and may occur. There also may be temporary bruising in the treated area.
* HYPOPIGMENTATION/HYPERPIGMENTATION (changes in skin color)- During the healing process, there is a slight possibility that the treated area may become either lighter (hypopigmentation) or darker (hyperpigmentation)in color compared to the surrounding skin. This is usually temporary, but on a rare occasion, may be permanent.
* WOUNDS- Treatment can result in burning, blistering, or bleeding of the treated areas. If this occurs, please call out office.
* SUN EXPOSURE/TANNING BEDS/ARTIFICAIL TANNING- May increase risk of side effects and adverse events
* INFECTION- Infection is a possibility whenever the skin surface is disrupted, although proper wound care should prevent this. If signs of infection develop, such as pain, heat, or surrounding redness, please call our office.
* SCARRING- Scarring is a rare occurrence but is a possibility if the skin surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.
* PARADOXICAL HAIR GROWTH- Stimulation of terminal hair growth following photo-epilation can occur within or adjacent to the treated area.
* LEUKOTRICHIA- Temporary or permanent gray hair may occur in very rare occasions.
* EYE EXPOSURE- Protective eyewear (shields) will be provided to you during treatment. Failure to wear eye shields during the entire treatment may cause severe and permanent eye damage

I acknowledge the following points have been discussed with me:

* Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me.
* Alternative treatments such as sclerotherapy or surgery
* Reasonably anticipated heath consequences if this procedure is not performed
* Possible complications/risks involved with the proposed procedure and subsequent healing period

For women of childbearing age:

By signing below, I confirm that I am not pregnant and do not intend to become pregnant anytime during the course of treatment. Furthermore, I agree to keep Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and staff informed should I become pregnant during the course of treatment.

Photographic documentation will be taken. I hereby do\_\_\_\_\_ do not\_\_\_\_\_ authorize the use of my photographs for teaching/promotional purposes.

**ACKNOWLEDGMENT**

**BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS INFORMED CONSENT FOR TREATMENT OF VASCULAR AND/OR PIGMENTED LESIONS/COLLAGEN STIMULATION, AND THAT I HAVE HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION BY MY HEALTHCARE TEAM.**

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**Signature-Patient or Guardian Print name/Relationship Date**

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**Signature- Witness Print name Date**