A Woman's Place

Patient Name:_____D.O.B._____Date:_____

LASER HAIR REMOVAL INFORMED CONSENT FORM

What is Laser Hair Removal? A laser produces a beam of highly concentrated light. Different types of laser produce different colors of light. The color of the light produced by a particular laser is the key to its effect on hair follicles. The light emitted by the Cynosure laser is absorbed by the pigment located in the hair follicle. The laser pulses for a fraction of a second, just long enough to vaporize the pigment, disabling several follicles at a time to eliminate or significantly impede the hair's growth. During each treatment session a laser light will be applied to the area of hair growth you have requested to be treated. These areas may be photographed before each treatment. You must wear protective eyewear during the treatment to protect your eyes from the intense light.

Laser hair removal treatment is an FDA approved method for permanent reduction of hair. Clinical results may vary with different skin types, hair color, and treatment area. This procedure works on the *growing* hair follicles, not dormant hair. For example, at any given time the upper lip has 65% of hairs in the growth or **anagen** phase and 35% in the resting or **telogen** phase. For this reason, complete destruction of all hair follicles from any one treatment is unlikely. Thus, multiple sessions may be required at regular scheduled intervals to obtain significant, long term reduction of hair growth. Each individual's treatment response is different and in a given individual different body areas react differently. It may take up to 4 weeks for the treated hair to fall out after each treatment.

Risks and Complications: Individual responses to the Cynosure laser pulse vary; some feel no discomfort and some minimal discomfort, but this is for a short duration. After a session, there may be a sensation like a mild sunburn. The use of sunblock is mandatory throughout your treatment course.

Scarring: To avoid the chance of scarring, it is important that you follow all instructions carefully. Whenever there is any disruption of the skin surface a rare possibility exists of hypertrophic scars (enlarged scars), and keloid scars (abnormal, heavy raised scar formation).

Blistering, Scabbing: Should this occur you must contact our office immediately so that we can advise you and document the occurrence. Please do not pick at the blister or scab.

Pigment or color changes: Some patients have a predisposition to this type of reaction (darkening of skin) and may have experienced it with minor cuts or abrasions. To minimize the chances of skin darkening in the treated area, avoid sun exposure or tanning 4 weeks before and 2 weeks after treatment. In some darker skin colors, darkening of the skin may occur even though the area has been protected from the sun. The darkening usually fades away in 1-4 months on its own. Rarely, however, the dark area may become permanent. In some patients, the treated area may become lighter in color than the surrounding skin. This *hypopigmented* area will gradually return to normal over a period of 1-4 months. Rarely, however, lightening of the skin becomes permanent.

Patient Name:_____D.O.B._____Date:_____

Contraindications: Contraindications include pregnancy, accutane, epilepsy, or those who have a history of seizures, diabetes (we do not treat below the elbows or knees), chemo or radiation therapy, pacemaker, internal defibrillator, any metal device (surgical screws, pins, plates or implants) in the area to be treated, HIV positive (a letter of clearance is needed), multiple sclerosis (a letter of clearance is needed with confirmation that the area to be treated is not numb), scleroderma, lupus, sarcoidosis, treatment over numbness of any body part, over moles or lesions of any kind, over tattoos (or permanent makeup), port wine stains, under the eyebrows, or any orifice. Use of photosensitive medications may cause increased skin sensitivity to Cynosure laser treatment.

Please answer Yes/No to each of the following statements:

_____ Sun exposure in the last 4 weeks
_____ Pregnancy/breastfeeding
_____ History of keloid scarring
_____ History of seizures
_____ Undiagnosed menstrual dysfunction
_____ Accutane (isotretinoin) in the last 12 months
_____ Have ever received Gold therapy
_____ Use of exfoliant products
_____ Have suspicious pigmented lesions
_____ Take medications known to cause photosensitivity (sensitivity to light)
_____ Are hypersensitive to light in the infared, or near infared wavelength region
_____ Have metal implant(s) in the treatment area
_____ Take anticoagulants
_____ Have lupus
_____ Take anticoagulants
_____ Open lesions
_____ Herpes or cold sores
_____ Retin A topical
_____ Antibiotics in last 30 days
_____ Glycolic Acid

Please acknowledge understanding of the following:

I understand that, while there is a risk of inadvertent harmful eye exposure, safeguards have been provided including the use of protective eyewear during treatment. I will keep the protective eyewear/goggles on at all times during treatment. _____(patient initials)

I understand that there are other options for hair removal such as electrolysis, waxing & chemical preparations. I understand the difference between these options and laser treatment, and am choosing laser as a non-invasive treatment for my hair removal. _____(patient initials)

I understand that if I have had sun exposure or used a tanning bed/self tanner within a 7 day period of YAG (1064nm) treatment or within a 4 week period of Alex (755nm) treatment, I risk a possible skin pigment change or blistering. _____ (patient initials)

I understand that there is a **24 hour cancellation policy**, and a $50 **minimum fee** or half of the treatment cost will be charged, whichever is greater, if I fail to show or do not cancel at least 24 hours prior to a scheduled appointment. _____ (patient initials)

I have received post treatment instructions and fully understand them. I understand that if I do not follow all of these instructions there may be consequences such as skin pigment changes, blistering, or other undesired outcome. _____ (patient initials)

I understand that if I have a tattoo or permanent make-up in the area to be treated, that area, and a safe surrounding margin will not be treated. However, there is still a possibility of blistering and lightening of the tattoo or permanent make-up. _____ (patient initials)

Summary: The consultant has explained the theory of the Cynosure Laser, any risks, including possible complications and benefits. Alternative methods of removing excess or unwanted hair are shaving, waxing, plucking, bleaching and electrolysis. The minimum number of laser hair removal treatments for optimum results are: 6 treatments for skin types 1-3, and 8-12 for skin types 4-6. The consultant has also explained treatment protocol, laser safety and necessary precautions. _____ (patient initials)

I have been given the opportunity to ask any questions and have received satisfactory answers. I certify that I have read and understand this entire consent form, and I have been given written pre and post procedure instructions, to which I will adhere. I have no further questions and am therefore giving my consent for laser hair removal. _____ (patient initials)

I further understand that A Woman's Place (or any representative) cannot guarantee the results and I will not hold A Woman's Place or their employees responsible for my individual results of the hair removal treatment that I have requested. _____ (patient initials)

I understand that I may not be a candidate for laser hair reduction, and upon consultation the Doctor or Technician will determine whether or not I am able to receive treatment.

Print Patient Name:_____ D.O.B._____

Signature:_____Date:_____
(Parent/Guardian if under 18)

Witness:_____ Date:_____

FITZPATRICK SKIN TEST
MODIFIED
SKIN TYPE EVALUATION

SCORE	0	1	2	3	4	YOUR SCORE
Your natural eye color?	Gray, very light Blue or Green	Med: Gray, or Green	Blue	Brown	Brownish Black	
Natural color of your hair?	Sandy or Red	Blond	Chestnut or Dark Blond	Dark Brown	Black	
Color of your *non exposed* skin?	Reddish	Very, Very Pale	Pale with Beige Tint	Light Brown	Dark Brown	
Do you have freckles on *non exposed* areas?	Many	Several	Few	Incidental	None	

GENETIC DISPOSITION SCORE _____

SCORE	0	1	2	3	4	YOUR SCORE
What happens if you stay too long in the sun?	Painful redness, blistering, peeling	Blistering, followed by peeling	May Burn, occasionally followed by peeling	Rarely burns	Never burns	
To what degree do you turn brown?	Not at all, or Hardly	Very Light color tan	Reasonable tan	Tan very easily	Turn dark brown quickly	
Do you turn brown within several hours after sun exposure?	Never	Rarely	Sometimes	Often	Always	
How does your face react to the sun?	Very sensitive, turns bright red quickly	Sensitive, somewhat reddens	Normal, minimal reaction	Very resistant	Never had a problem	

SUN REACTION SCORE _____

SCORE	0	1	2	3	4	YOUR SCORE
When did you last expose the area to be treated to sun, tanning booth, cream, or spray tan?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago	
Have you exposed the area to be treated to the sun, tanning booth, cream or spray tan?	Never	Hardly ever	Sometimes	Often	Always	

TANNING HABITS SCORE _____

TOTAL SCORE _____

If your total score is:	Then your Fitzpatrick skin type is:
0-7	I
8-16	II
17-24	III
25-30	IV
Over 30	V-VI

A Woman's Place

Health History

To ensure both the effectiveness and safety of your treatment, please complete this health history as accurately as you can.

Personal Information

Date:_____

Last Name:_____ First Name:_____ M.I._____

D.O.B._____ Preferred contact phone #:_____

Occupation: _____

I am interested in treatments for:

☐ Hair reduction
☐ Leg/Spider vein reduction
☐ Skin/Photorejuvenation
☐ Pigmented lesion treatment

Desired body area(s) for treatment:

_____

_____

_____

Medical History

Do you use sunscreen? ☐ YES (SPF#_____) ☐ NO

Please answer YES(Y) to all that apply, NO(N) to those that do not apply

_____ Acne _____ Hirsutism _____ Shingles
_____ Arthritis _____ Vitiligo _____ Skin Pigmentation
_____ Autoimune Disorder (including HIV) _____ Kidney disease
_____Steroid therapy _____ Hormone therapy _____Thyroid disorders
_____ Melanoma _____Hormonal imbalance _____ Cancer
_____ Polycystic Ovarian Syndrome _____Port Wine Stain
_____Diabetes _____Psoriasis _____Keloid Scars
_____Diabeic Neuropathy _____ Herpes (or cold sores)
_____ Pacemaker _____Other Scars _____ Seizures
_____ Blood disorders/Aspirin _____ Pregnant/Breastfeeding
_____ Pacemaker _____ Numbness on any part of your face/body

Medications: (please list all medications and supplements you are currently taking or applying to skin as well as ALL **antibiotics** taken in the last 30 days, **Accutane** taken in the last 12 months, and history of **Gold therapy**)

_____ _____
_____ _____
_____ _____

Patient Name:_____ D.O.B._____

Additional Questions:

1. Are you currently being treated for any conditions not listed? If yes, please specify:

_____

2. Do you have any **Allergies?** If yes, please specify:

_____

3. Have you ever used (or are you using) Retin A or Glycolic Acid? If yes, specify:

_____

4. Have you ever used (or are you using) Accutane? If yes, please specify:

_____

5. Have you ever had a chemical peel? If yes, please specify type and date:

_____

6. Have you had any laser treatments? If yes, please specify:

_____

7. What products are you currently using on your skin?

_____

8. Do you have any tattoos or permanent makeup in the area to be treated? If yes, please specify:

_____

9. Have you ever been treated by an endocrinologist or other physician for a hormone imbalance? If yes, please specify:

_____

10. Do you sunbathe, use tanning booths or self-tanning lotions/creams/sprays? If yes, please specify which type, how often, and when your last exposure was:

_____

11. Have you ever had Gold Therapy (used for arthritis)? _____

12. Are you currently pregnant or have you delivered a baby in the last 8 weeks? If yes, please specify:

13. Are you breastfeeding or have you breastfeed in the last 8 weeks? If yes, please specify:

14. Have you had Restylane, Perlane, L, Hylaform or Botox injections in the area to be treated? If yes, please specify:

15. Do you have a history of keloid scarring? If yes, please specify:

16. Are you taking any medications that cause sensitivity to light? If so please specify:

17. Do you have any particular skin sensitivities? If yes, please specify:

18. Do you have any areas of numbness/nerve damage? If yes, Please specify:

19. Is there any other information we should be aware of?

Please sign below to indicate all information is accurate and complete

Patient Name: _____

Signature: _____
(Parent/Guardian if minor)

Witness: _____ Date: _____

Pre/Post Procedure Instructions for Cynosure Apogee Elite Laser Treatments

Thank you for scheduling your Laser treatment with A Woman's Place. The following instructions should be followed diligently in order to obtain optimum results.

- No waxing, tweezing, bleaching or depilatories of the treatment area during the entire course of your treatments. Shaving or clipping is permitting as often as desired.

- Shave the treatment area the day of your procedure unless instructed otherwise. Thick overlying hair will absorb the laser energy reducing the amount of energy absorbed by the hair follicle (making treatments less effective). Superficial thermal injury can occur as well due to overlying hair. If you cannot shave, we will shave the area for you for an additional charge of $35 each treatment.

- Do not use the following on treated areas: Skin lighteners, Retinols, exfoliation products or bleaching creams 2 days prior and 2-3 days after treatment or until all pinkness has subsided.

- Do not apply any creams, lotions, make-up or deodorant on the area to be treated prior to treatment.

-No direct sunbathing, tanning booths and self-tanning products 4 weeks prior and 2 weeks after your treatment. If any sun exposure to the area is possible, a broad spectrum sunscreen (UVA/UVB) SPF 30 or higher should be applied.

- To wash- use mild soap and tepid water. Do not use hot water on freshly treated areas until all pinkness has subsided. DO NOT expose the area to hot/warm water (ie:hot tub, bath)

- Aloe Vera should be applied to the area for rehydration. If crusting develops it should be allowed to fall off naturally. Do not scratch or pick crust. If crusting or blistering occurs, do not shave the area for 3 days post-treatment.

- Normal skin care regimen (make-up, deodorant, lotions, shaving) can be resumed the next day if there is no redness, crusting or blistering present.

- The hairs that are destroyed from your treatment will gradually work themselves out. This process can take 3-4 weeks. Do not pick, rub or scratch treated areas.

- Although extremely rare, if the area appears to be forming a blister, you must call our office immediately so that we can arrange for an evaluation and document the occurrence.

- If you must cancel or reschedule your appointment, please contact our office at least 24 hours in advance to avoid being charged a late cancellation/no-show fee. This fee is $50 OR 50% of the cost of your treatment, whichever is higher. This is due to the high demand of our treatment time.

If you have any questions or concerns, please contact our office at (480)325-5885. We look forward to seeing you at you next appointment and strive to meet or exceed your expectations for your laser treatments.