Donna Johnston, MD

Laser Hair Removal Informed Consent Form

_____ I am not pregnant, nursing, or trying to become pregnant.

_____ I have stopped use and been off of all antibiotics, or any other drug that may cause photosensitivity, for at least 7 days.

_____ I have not used Accutane or any other isotretinoin medication in the past 6 months.

_____ I have not used self tanner in the area to be treated in the past 7 days.

_____ I have not received electrolysis, tweezed, waxed, threaded, or removed hair from the follicle by any method other than shaving in the past 3-4 weeks.

_____ I am aware if I have herpes simplex virus 1 or 2, I need to be on an oral antiviral medication at least 2-3 days prior to laser treatment.

_____ For best results, I have been informed that multiple treatments may be necessary, and treatments need to be scheduled consecutively; it is recommended they are scheduled 4-6 weeks apart.

_____ I understand that if I have had laser hair removal treatments somewhere else, it may not be the same as the laser treatment I receive at Donna Johnston, MD.

_____ I understand complete removal and/or clearing of my hair may not be possible.

_____ I understand maintenance may be needed after my initial series of treatments; and, new hair growth may occur in the treated area. This new hair growth may be caused by various factors including age, hormones, and/or new medications.

_____ I understand the risks and complications that may be associated with this procedure. I have been informed the risks and complications my include, but are not limited to:Bruising and purpura (red-purple discoloration),Bleeding, Infection, Hyperpigmentation (darkening of the skin) and may be permanent,Hypopigmentation (lightening of the skin) and may be permanent,

Itching or a hive-like response, Burns, blisters, textural changing or scarring, Swelling, redness and/or discomfort.

_____ I am aware this procedure may activate individual sensitivities: may include, but are not limited to herpes simplex virus, which can cause cold sores and fever blisters, hirsutism (increased hair growth), and/or enlarged lymph nodes.

_____ After laser treatment, redness, swelling, welting, itching, dry skin and/or discomfort may occur which typically resolve within a few hours, days, weeks, or months; however, some complications such as scarring, hyperpigmentation, and/or hypopigmentation may be permanent.

_____ I understand any redness, swelling , and/or discomfort usually resolves within several hours, but may last for 2-3 days. The treated area may feel like a sunburn or windburn (minor discomfort) for a few hours after treatment and may be treated with the application of cool compresses, antibiotic ointment, Aquaphor, and/or topical soothing agents.

_____ I am aware I will be given aftercare instructions regarding care of the treated area(s). I understand it is important to follow all aftercare instructions carefully to minimize the risks of incomplete healing, scarring, and/or skin textural changes.

_____ I am aware that there are other methods of treatment available for hair removal and have assessed the risks and benefits of laser hair removal and these alternative methods.

_____ Anesthesia is usually not necessary for this procedure. My provider and I may elect to use a form of anesthesia to reduce my discomfort during the procedure.

_____ I understand I need to avoid direct sunlight, because sun sensitivity of the treated area may remain for several weeks after a laser treatment. I need to protect my skin from the sun using a broad spectrum UVA/UVB protective sunscreen to reduce the risk of damage to the skin. I understand I must wear a broad spectrum UVA/UVB protective sunscreen whin I am exposed to sunlight including when sitting in the car, walking to the mailbox,sitting next to a window.

_____ I understand my skin may be sensitive for a week or more after laser treatment and I should avoid using extremely hot water and skin care products that may contain irritants such as scrubs, toners, retinoids, glycolic acids, anti-aging ingredients, and/or acne products.

_____ I understand hair growth occurs in cycles: only hair in the Anagen phase of growth responds to laser hair removal. The duration of hair cycle and percentage of hair in the Anagen phase is different for all areas of the body. Age, ethnicity, metabolism, medications, and changes in hormones affect the location, resilience, and thickness of hair. I understand these factors influence the success of laser treatments, why multiple treatments are needed and , why we are unable to predict the number of treatments each individual will need to be satisfied with the results.

_____ I am aware this is not covered by my insurance and I know I am responsible for payment of these services with no fee reimbursement regardless of procedural results. I understand the fee paid is for the procedure and not for an expected result. I understand the payment is due the day of my procedure.

_____ I understand, recognize, and acknowledge Dr. Donna Johnston, the nurse practitioner, and any other staff members of Donna Johnston, MD have made no guarantees to me concerning the results of my laser treatments.

_____ I have provided my past and current medical history and medications.

_____ Contraindications of this procedure have been discussed in detail with me.

_____ I have read and understand all information presented to me concerning this procedure before signing this consent form.

_____ Questions I have about the risks, benefits, and results pertaining to this procedure have been answered and discussed to my satisfaction.

Patient name: (printed)_____Date:_____

Patient signature:_____Date:_____

Staff/witness Signature: _____Date:_____

Physician signature:_____Date:_____