CONSENT FORM
FOR LASER & LIGHT BASED HAIR REMOVAL

I hereby authorize Dr. Bartlett or any delegated associates to perform laser or light based hair removal on me. I understand that this procedure works on the growing hairs and not on dormant hairs. For this reason, complete destruction of all hair follicles from any one treatment is unlikely. I understand that I will require several treatments to obtain a significant, long-term reduction of hair growth. I understand I may experience fewer, thinner, lighter, slower re-growth 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 red hair. I understand that genetics, hormones, medication and hair color may interfere with hair loss and that I may not respond at all.

I am aware of the following possible experiences/risks:

- **DISCOMFORT** – 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 some bruising.
- **PIGMENT CHANGES** (Skin Color) – During the healing process, there is a possibility that the treated area can become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- **SUN EXPOSURE / TANNING BEDS / ARTIFICIAL TANNING** - May increase risk of side effects and adverse events.
- **WOUNDS** – Treatment can result in burning, blistering, or bleeding of the treated areas. If any of these occur, please call our office.
- **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 (617) 735-1800.
- **SCARRING** – Scarring is a rare occurrence, but it 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 carefully.
- **PARADOXICAL HAIR GROWTH** – Stimulation of terminal hair growth following photoepilation. Can occur within or adjacent to treated area.
- **LEUKOTRICHIA** - Temporary or permanent gray hair.
- **EYE EXPOSURE** – Protective eyewear (shields) will be provided. It is important to keep these shields on at all times during the treatment in order to protect your eyes from injury.
- **COMPLIANCE** – Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, and hyperpigmentation.

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
- Possible alternative procedures such as electrolysis, waxing, plucking and depilatories
• Reasonably anticipated consequences if the procedure is not performed
• Most likely possible complications/risks involved with the proposed procedure and subsequent healing period
• Post-treatment instructions
• Short term effects may include reddening, mild burning, temporary bruising or blistering. Hyperpigmentation and hypopigmentation have also been noted after treatment. These conditions usually resolve within 3-6 months but permanent color change is a rare risk. Avoiding sun exposure before and after the treatment reduces the risk of color change.

For women of childbearing age: By signing below I indicate that I am not pregnant. Furthermore, I agree to keep Dr. Bartlett and staff informed should I become pregnant during the course of treatment.

Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. My questions regarding the procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release Meaghan Consedine RN, BSN, Dr. Richard Bartlett and Beautiful Skin Boston from all liabilities associated with the above indicated procedure.

**ACKNOWLEDGMENT AND RELEASE**

BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS PERMISSION FORM FOR LASER AND LIGHT BASED HAIR REMOVAL TREATMENT, AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.

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Signature-Patient or Guardian  Print Name/Relationship  Date