

## GentleLASE Consent Form

I hereby authorize Dr. Warnock's office to perform laser hair reduction with the Candela GentleLASE laser on me.

I have been informed that laser hair removal is a procedure by which hair from my body can be removed utilizing the Candela GentleLASE laser. Laser hair removal involves matching laser light and pulse duration to the follicle size, depth and location to inhibit re-growth of the removed hair. A technician will distribute the light of an Alexandrite Long Pulse Laser (755nm) onto the skin to perform laser hair removal. The laser works by disabling the hairs that are in the active cycles at the time of treatment. I understand that I will have to wear protective eyeglasses during the course of the treatment to protect my eyes from the laser light.

I am aware that the laser treatment can produce, but is not limited to the following common side effects: redness, swelling, welting, itching, tingling, and dry skin. I understand that these side effects usually last from 2 hours to a couple of days.

**I understand there are risks and complications that can occur from a laser treatment that can interrupt my daily life, work routine or social life.** These may include but are not limited to: burning, scab formation, heat rash, bruising, scarring, infection, hypopigmentation (lighter skin), and hyperpigmentation (darker skin). If any of these were to occur, I understand our affiliated physician is available to see me and provide post treatment guidelines to speed my recovery time. If I choose to consult my own physician or seek any other medical attention, it is at my own expense.

For best results, I have been informed that multiple treatments will be needed. For most areas 6-8 treatments are necessary to achieve desired hair clearance. I understand that more than 6 treatments may be needed depending on hair type, previous methods of hair removal and skin color. I understand that results are not guaranteed. Some of the factors that could trigger new hair growth are hormonal imbalance, pregnancy, medications, menopause, tweezing or waxing.

I understand that tanning during the course of my laser treatments is not recommended and can cause a number of complications. I understand that I should avoid direct sun exposure for 2 weeks after my laser treatment, this also includes tanning beds. I have been informed to use a sunblock with an SPF of 30 or higher on the treated area during the course of laser treatments. I understand that it is my responsibility to inform Dr. Warnock's office if my skin is any darker than when I first started treatment.

I understand post-treatment care is very important after the treatments and I will adhere to all the instructions given to me. Improper care to the treated area may increase the chances of any complications.

I consent to having photographs taken during the course of my laser treatments to be retained as part of my file maintained by Dr. Warnock's office. I understand that all photographs are the property of Dr. Warnock's office and are kept confidential. I have read and understand all information presented to me before signing this consent. I have had ample opportunity to ask any questions regarding laser hair reduction, side effects and after care. I also understand it is my responsibility to inform Dr. Warnock's office of any medical or prescription changes.

Signed \_\_\_\_\_

On behalf of Dr. Warnock \_\_\_\_\_

Date \_\_\_\_\_

Date \_\_\_\_\_