James Aria, MD, PC & Nancy Aria, MD, PC
Informed Consent
Laser Hair Reduction

Patient's Name:____

Treatment Sites:____

I authorize James Aria, MD, PC & Nancy Aria, MD, PC to perform the laser hair reduction procedure with the 810 Diode Laser System

I understand that the Diode Laser device is used for laser hair reduction and that clinical results may vary in different skin types and hair types. _____________
Patient's initials

The following problems may occur with laser hair reduction treatment:

1. However slight, there is a risk of scarring _____________
   Patient's initials
2. Short term effects may include reddening, mild burning, temporary bruising or blistering. Hyper-pigmentation (browning) and hypo-pigmentation (lightening) 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 treatment reduces the risk of color change. _____________
   Patient's initials
3. Although unusual, bacterial, fungal, and viral infections may occur. Herpes simplex virus infections around the mouth may occur following a treatment. This applies to both individuals with a past history of herpes simplex virus infections and individuals with no known history of herpes simplex virus infections in the mouth areas. If you have a history of herpes simplex virus in the treated area we recommend preventive therapy. ___________
   Patient's initials
4. Bleeding: Pinpoint bleeding is rare but can occur following treatment procedure. _____________
   Patient's initials
5. Allergic Reactions: Laser light may trigger an allergic reaction in persons with a history of allergies. _____________
   Patient's initials
6. I understand that exposure of my eyes to laser light could harm my vision. I must keep the eye protection goggles on at all times. ___________
   Patient's initials
7. If you are currently have or had at one time, a tattoo in the area being treated, you must inform your technician prior to service. Not doing so may result in burns, blisters, discoloration and/or fading of the tattoo and/or skin. _____________
   Patient's initials
8. Itching caused by exfoliation of dead hair cells may occur. Additional treatment for the itching may be needed. _____________
   Patient's initials
9. Compliance with the aftercare guidelines is crucial for healing, prevention of scarring, and hyperpigmentation. ___________
   Patient's initials

Clinical results may vary depending on individual factors, including medical history, skin and hair type, patient compliance with pre/post treatment instructions, and individual response to treatment. I understand that epilation with the laser hair reduction device is a safe alternative to methods used for removing unwanted hair, such as shaving, waxing, chemical epilation and

electrolysis. ______________
Patient's initials

I understand that treatment by the laser hair reduction device involves a series of treatments and the fee structure has been fully explained to me. The total number of treatments will vary between individuals. On occasion, there are patients that do not respond to treatments. The treated hair should exfoliate or push out in 2-3 weeks. ______________
Patient's initials

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. ______________
Patient's initials

I confirm that I am not pregnant at this time, and that I have not taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator. ______________
Patient's initials

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form. ______________
Patient's initials

I understand that it is recommended that I do treatment every 8 weeks. All treatment should be completed within 18 months of the start date. ______________
Patient's initials

Occasionally, unforeseen mechanical problems may occur and your appointment will need to be rescheduled. We will make every effort to notify you prior to your arrival. Please be understanding if we cause you any inconvenience.

Acknowledgement:

My questions regarding this procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release Nancy Aria, MD, PC and James Aria, MD, PC and their staff from all liabilities associated with the above indicated procedure.

Patient's Signature:________________________________ Date:________________

Witness Signature: _______________________________