



TIFFANI KIM INSTITUTE

MEDICAL • WELLNESS • SPA

Laser Hair Removal Consent Form

The procedure planned is laser-assisted hair removal using the Syneron Comet.

The purpose of this procedure is to diminish or remove hairs. This procedure may require one or more treatments and may not produce permanent hair removal. Alternative methods are electrolysis, other laser-assisted hair removals, and various topical therapies (ie shaving, etc.)

I understand that the risks of this procedure include possible pain, infection, scarring, drug reactions or interactions or unforeseen complications. There is also a risk of mismatch in the color or the texture of the skin, temporary redness, hive-like reaction or bruising, brownish skin discoloration, activation of fever blisters (herpes), temporary increase susceptibility to sunburn or persistent pinkness for months.

I understand that there is a possibility that this procedure will fail, be unsuccessful, need to be repeated, or may require additional treatment of complications. If tattooed “permanent” make up or a “decorative” tattoo is in the area to be treated with laser hair removal, lightening of decorative tattoos, or blackening of makeup tattooing can occur.

I understand my responsibility for properly fulfilling the appropriate aftercare instructions as it is explained by a certified Aesthetician, board-certified physician assistant, or board-certified dermatologist at *Tiffani Kim Institute*.

Although part or all the cost of this procedure may, in rare situations, be reimbursed by insurance companies, many policies/companies consider this procedure cosmetic or not covered for various other reasons. I understand that I am responsible for all cost whether or not covered by my insurance.

I have been asked at this time whether I have any questions about this procedure, and I do not. I have complete understanding of both pre and post care instructions. I understand the procedure and accept the risks, and request that this procedure be performed by a provider at *Tiffani Kim Institute*.

Clients Signature: _____

Date: _____

Clients Name: _____
(Please Print)

Providers Signature: _____

Date: _____

Providers Name: _____
(Please Print)



Laser Hair Removal Pre & Post Treatment Care

Avoid any of the medications or treatments:

1. Area to be treated should be shaven within 24 hours of treatment for optimal results.
2. Stop using Accutane 1 year prior to the treatment
3. Any type of Chemical Peel 2-4 weeks prior and after the treatment on the area to be treated.
4. Stop applying Retin-A, Renova, Tazorac, Differin, and Atralin 2 days prior and after, to the treatment area
5. Stop sun tanning or using the tanning bed 2-4 weeks prior and after, to your treatment.
6. Stop any type of depilatory treatments (waxing, depilatory creams) to the area of treatment, 4 weeks prior and the duration of your series.

I understand that because laser treatment will make my skin more sensitive to the sun, I will protect my skin, by applying a sunscreen with **SPF 45 or higher** every day for the duration of my treatments and for several months after the last treatment. I also understand that the use of tanning bed causes the same amount of damage on my skin as the sun; therefore, I need to stop using the tanning bed before, during, and after my treatments.



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Name: _____ Age _____ Sex _____ Date _____

Area(s) to be treated today: _____

Skin Type (I-IV): Fair Olive Dark Asian/Hispanic Black

Hair Type: Coarse Fine Comments: _____

Hair Color: Black Brown Red Blonde Gray Other

Allergies: _____

Are you Pregnant? Yes No

Are you currently taking any medications?

(Please list if any, Accutane, Aspirin, Antibiotics, Antiviral, Coumadin, Photosensitivity drugs such as St. John's Wort)

List medications and dosages:

Please list any topical medications you are using:

Present Illnesses (including history of any autoimmune disease, HSV1, or HSV2):

Recent cosmetic procedures in area to be treated (chemical peels, exfoliation, injectables, tattoos):

History of keloids/hypertrophic scars: Yes No

Tanning history (including direct sun, self tanners, spray tans) Please list and include last date of use:



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Previous Laser Treatment: (specify date/number of treatments/frequency/tissue response/device used, if known):

Previous Hair Removal History, if applicable:

- Wax epilation
- Mechanical Epilation
- Electrolysis
- Previous Laser Treatment
- Bleaching
- Shaving

Frequency and last use of above modalities:

Other type of treatment: _____

FOR STAFF ONLY:

After reviewing the recommendations, please have client initial each item

Recommendations: Discussion with provider

- _____ 1. Discuss treatment options (*testing, color of hair responds best, number of treatments*)
- _____ 2. Discuss client expectations: understand need for multiple treatments, after care, possible side effects, etc.
- _____ 3. Review in detail full treatment schedule process (waiting period, when to expect re-growth, shaving ONLY 6 weeks prior to/after treatment)
- _____ 4. Discuss possible side effects (hyper/hypopigmentation, purpura, scarring) and length of time to expect healing if side effects occur.
- _____ 5. Discuss specifics of are to be treated, test small area for tissue response BEFORE full treatment (provider should protect eyes/brow, nose, ears when treating)
- _____ 6. Discuss avoidance of sun exposure and the use of sunscreen during entire program.
- _____ 7. Discuss sensation of laser and the option for topical anesthesia.
- _____ 8. Discuss benefits of laser treatment, possible long-term hair removal, and laser safety.
- _____ 9. Discuss cost (payment schedule, cost of multiple versus single payment per visit).

Comments:

I agree that the information listed above has been reviewed and presented with my clear understanding of what this procedure involves. All of my questions have been answered to my satisfaction.

Signed: _____ Date: _____

Witness: _____ Date: _____