BA MED SPA & WEIGHT LOSS CENTER
INFORMED CONSENT FOR LASER HAIR REMOVAL

Patient Name_____ Date_____

The purpose of laser hair removal is to diminish or remove unwanted hair. In signing this document, I give permission to the clinic staff of BA Med Spa to perform the laser hair removal procedure. I understand that the goal of this procedure is the gradual permanent reduction of my hair.

I understand that every individual is unique, and it is very difficult to guarantee a specific number of treatments needed. Most clients will need a minimum of 6 to 8 sessions. On rare occasions, there may be a client that does not respond to treatment. _____ (initial)

I have shaved the area to be treated within the last 24 hours. _____ (initial)

I acknowledge that I have not waxed, plucked or threaded the treated area within the previous six weeks. I also acknowledge that ***I HAVE NOT BEEN SUN TANNING, EITHER ARTIFICIAL OR ACTUAL WITHIN THE PREVIOUS SIX (6) WEEKS.*** _____ (initial)

I have not used self tanner in the area to be treated since my last treatment. _____ (initial)

I have stopped use and been off all antibiotics, or any other drug that may cause photosensitivity for at least 7 days and have not used Accutane in the last year or any other isotretinoin medication (including Retin-A) in the past 6 months. _____ (initial)

I am not currently pregnant, nursing or trying to become pregnant and agree to inform the clinic should I become pregnant. _____ (initial)

I am not allergic to topical anesthetic (topical freezing). _____ (initial)

Contraindications include items listed above, as well as, epilepsy, history of seizure disorder, diabetes, chemo or radiation therapy, pacemaker, internal defibrillator, or any internal metal device in the area to be treated, HIV Positive*, multiple sclerosis*, scleroderma, lupus or sarcoidosis. We will not treat areas with moles or lesions, tattoos, port wine stains, under the eyebrows or in any orifice. _____ (initial)

Infection following treatment is quite unusual, but bacterial, fungal and viral infections can occur. Herpes simplex virus infections around the mouth can be stimulated by laser 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 area. Should any type of skin infections occur, additional skin treatments or medical antibiotics may be necessary. Short term effects may include reddening, swelling, bumps, mild burning, temporary bruising or blistering. Hyperpigmentation (browning of skin) and Hypopigmentation (lightening of the skin), although rare, may occur. These conditions usually resolve within 3-6 months, but permanent color change is possible. Avoiding sun exposure before and after treatment for a minimum of six weeks reduces the risk of color change. _____ (initial)

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 to the office. Our office number is 918-872-9999. Please be understanding if we cause you an inconvenience. _____ (initial)

By signing below, I acknowledge that I have read the adverse reactions above and I feel that I have been adequately informed of the risks of Laser Hair Removal treatments. Before each treatment I will inform the laser technician if I have taken any new medications since my last treatment or if I have tanned, either by sunlight or artificially with the last six (6) weeks. I understand that tanning and some medications can make my skin photosensitive, and tanning is a direct contraindication. I also understand that either of the aforementioned conditions could cause the laser to damage my skin. I also agree to comply with the recommended aftercare instructions which are crucial for healing and prevention of scarring and hyperpigmentation.

ACKNOWLEDGEMENT: My questions regarding the Laser Hair Removal procedure have been answered satisfactorily. I understand the procedure and accept the risks. I hereby release BA Med Spa & Weight Loss Center and its designated staff from all liabilities associated with the above indicated procedure.

_____ _____ _____

Client/Guardian Signature Date Witness

*Requires a letter of clearance from dermatologist or primary physician.