



EN Signature Brows & Beauty Studio

DIODE 810 LASER HAIR REMOVAL CLIENT CONSENT

I, _____, have given Certified Esthetician Elizaveta Neginskaya LLC.

(Client's name)

permission to perform Diode laser procedures using light-based therapy methods.

DIODE 810 laser is FDA approved for a variety of procedures including hair removal, vascular lesions, onychomycosis, PFB, psoriasis, rosacea/bruising, tattoo removal, pain management, pigmented lesions, scar reduction/revision, melasma, acne reduction, skin rejuvenation/ tightening, warts/skin tags and wound healing. I understand that light-based therapy offers varying intensities of light. I understand that these are relatively new medical cosmetic procedures and that the long-term studies are ongoing. Although the laser treatment is effective in most cases, no guarantee can be made that a specific patient will benefit from the treatment. I do understand other forms of treatment exist. The purpose of this selected light-based therapy treatment is an attempt to improve the appearance of the specific conditions listed above. I am aware that multiple consecutive treatments may be necessary to achieve satisfactory results. They are repeated, within protocol, until the desired level of appearance and hair removal is observed.

The laser emits an intense beam of light that is absorbed in specific body tissues within the skin, and depending upon the type of procedure, several treatments may be required at intervals specified by Liza. This form is designed to give you the information you need to make an informed choice of whether or not to undergo DIODE laser treatment. If you have any questions, please do not hesitate to ask

Some of the possible complications of DIODE laser treatment are:

1. Discomfort - The procedure is done so precisely that surrounding tissue is minimally affected; the client may experience a mild sensation of pain, burning, blister formation, crusting of the skin and stinging sensation, and some edema(mild swelling) in the treated areas. Improper post treatment care can result in infection and possible pigmentation changes as well as increase the risk of complications. Irritation and redness typically resolve within 72 hours or less. A topical anesthetic (Dr. Numb) may be used to minimize discomfort.

Initials_____

2. Scarring - There is a small chance of scarring, although rare. This includes hypertrophic scars, or very rarely, keloid scars. Keloid scars are very heavy raised scar formations. To minimize chances of scarring, it is important that you follow all postoperative instructions carefully. It is important that any prior history of unfavorable healing be reported. Accutane (isotretinoin) use must be discontinued for 6 months prior to laser treatment to prevent severe scarring. A written consent for treatment from your physician may be required. Initials_____

3. Pigmented changes - Color changes, such as Erythema (pink color), hyperpigmentation (darker, brown, red), hypopigmentation(skin lightening) may occur in treated areas. This may take several months to return to normal. However, pigment change can be permanent. There may also be possible hair removal at treatment site. It is recommended that you protect yourself from any sun exposure for at least three months following treatment.

Initials_____



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LASER HAIR REMOVAL CONSENT

4. HSV Reactivation - The client agrees to notify Liza if he/she has any history of Herpes viral infections (oral, nasal, genital) as the laser procedure may cause it to reactivate. Laser-induced cold sore-like blistering may appear. It is recommended that Valtrex (acyclovir) be taken prior to treatment to avoid an outbreak.

Initials _____

5. Lack of Treatment Response - There is a possibility that the targeted hairs, or other treated areas will not respond to the treatment. This is often a function of the specific body chemistry of the client, including relative pigmentation and light absorption characteristics of the client's various body tissues. Reoccurrence of hair growth at treatment site is also a possibility. Initials _____

6. Eye Exposure - There is also the risk of harmful eye exposure to laser surgery. Safeguards should be provided by the laser practitioner. It is important that you keep your eyes closed and have protective eye wear at all times during the laser treatment.

Initials _____

7. Photographs - I consent to be photographed before, during, and after the treatment and that these photographs shall be the property of the above doctor and may be used during treatment stages for future comparison. Photographs may possibly be used for marketing reasons.

Initials _____

8. Client and all personnel in treatment room must use proper eye protection; which is deemed necessary by the manufacturer of the medical equipment being operated and is in accordance with OSHA regulations.

REFUND POLICY:

Individual services, promotional services, sale services, series services, gift certificates purchased for yourself or for another individual are absolutely non-refundable. This applies to all of the procedures offered at the salon. There are NO REFUNDS on any procedures or services we have already initiated or already completed. NO EXCEPTIONS. _____ **(Initials)**

My signature below constitutes my acknowledgment that I _____, am a competent, consenting adult of at least 18 years of age (or my parent or legal guardian is giving consent on my behalf). I certify that I have read or have had read to me, the content of this informed consent form. I understand the risks and alternatives involved in this procedure. I have had the opportunity to ask any questions that I had and all of my questions have been answered. I have agreed to provide aftercare as directed for this treatment by this facility.

Client's Signature : _____ Date: _____