LOW COUNTRY
DERMATOLOGY

PATIENT INFORMED CONSENT FORM FOR LASER & LIGHT BASED HAIR REDUCTION

I hereby authorize Dr. Howington / Haley Spring / Jordan Walker to perform light based hair reduction to me. I understand that I will require several treatments to obtain a significant, long-term reduction of hair growth. I understand I may experience fewer, thinner, lighter, slower re-growth of hairs, temporary hair loss or permanent hair reduction. I understand that it is only effective on hair with color and does not treat white, grey, blond, or red hair. I understand that genetics, hormones, medication and hair color may interfere with hair loss and that I may not respond at all.

The procedure may result in the following adverse experiences or risks:

- **DISCOMFORT / PAIN -** Some discomfort and/or pain may be experienced during treatment
- **REDNESS / SWELLING / BRUISING -** Short term redness (erythema) or swelling (edema) of the treated area is common and may occur. There also may be some bruising.
- **HYPOPIGMENTATION / HYPERPIGMENTATION (Changes in skin color) -** During the healing process, there is a slight possibility that the treated area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- **WOUNDS -** Treatment can result in burning, blistering, pr bleeding of the treated areas.
- **SUN EXPOSURE / TANNING BED / ARTIFICIAL TANNING -** May increase risk of side effects and adverse events. If any of these occur, please call our office at 912-354-1018.
- **INFECTION -** Infection is a possibility whenever the skin surface is disrupted, although proper wound care should prevent this. If signs of infection develop, such as pain, heat, or surrounding redness, please call our office at 912-354-1018.
- **SCARRING -** Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the chances of scarring, it is IMPORTANT that you follow all post-treatment instructions provided by your healthcare staff.
- **PARADOXICAL HAIR GROWTH -** Stimulation of terminal hair growth following photo-epilation can occur within or adjacent to the treated area.
- **LEUKOTRICHIA -** Temporary or permanent gray hair
- **EYE EXPOSURE -** Protective eyewear (shields) will be provided to you during the treatment. Failure to wear eye shields during the entire treatment may cause severe and permanent eye damage.

I acknowledge the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me

- Alternative treatments such as electrolysis, waxing, plucking, and depilatories
- Reasonably anticipated health consequences if the procedure is not performed
- Possible complications/risks involved with the proposed procedure and subsequent healing period

For women of childbearing age: By signing below I confirm that I am not pregnant and do not intend to become pregnant during the course of treatment. Furthermore, I agree to keep Dr. Howington / Haley Spring / Jordan Walker informed should I become pregnant during the course of treatment.

Photographic documentation will be taken. I hereby do ___ do not ___ authorize the use of my photographs for teaching purposes.

ACKNOWLEDGMENT

By my signature below, I acknowledge that I have read and fully understand the contents of this informed consent for light based hair removal treatment, and that I have had all my questions answered to my satisfaction by the healthcare team.

_____	_____	_____
Patient Signature	**Print Name**	**Date**
_____	_____	_____
Witness Signature	**Print Name**	**Date**