INFORMED CONSENT FORM FOR LASER/IPL THERAPY

I understand that a LASER/IPL is being used for a treatment on me under the direction of April Marie Glow, LLC. Although LASER/IPL therapy is safe and effective in the majority of cases, unexpected adverse events may occur. Unexpected side effects may result from the use of the laser, and the expected response of the treated area may not be achieved.

_____ 1. **Short term effects:** I understand there are multiple short term effects that may occur with LASER/IPL therapy, including reddening, irritated raised rash, mild burning, swelling, bruising, numbing, temporary pigmentary change, blistering, scabbing, crusting, flaking, and sensitivity to the sun. Although these effects typically resolve within several days, they may persist for several weeks and rarely, even longer. I understand that the degree of the side effects varies from person to person, and it may not be possible to predict how I will respond.

_____ 2. **Possible permanent effects:** I understand that although most side effects are short term and resolve fairly quickly, some effects may be permanent. Scarring and changes in pigmentation (lighter skin or darker skin) may be permanent.

_____ 3. **Discomfort associated with procedure:** I understand that the LASER/IPL functions by heating up its target (blood vessels, pigmentation). This heating sensation may be minimized by the use of the cooling device, but some level of discomfort may be felt. The level of discomfort depends on the treatment being done, and varies from person to person. The stinging or sensation of heat is typically short term but may persist for several hours after the procedure.

_____ 4. **Effects of UV**: I understand that sun exposure, tanning beds, sunless tanning lotions, and tanning creams can cause discoloration or reaction to LASER/IPL treatment during and after the procedure. Having any kind of tan prior to therapy or soon after therapy results in an increased chance of blistering, permanent or temporary discoloration, scarring, and discomfort. I understand that avoidance of any UV exposure 1 month prior and 2 weeks after treatment reduces the risk of these effects.

_____ 5. **People excluded from therapy:** I understand that certain patients should not have LASER/IPL treatment. This includes any patients who have sun exposure in treatment area, open wounds, malignant skin tumors, patients who have certain disease that make them sensitive to light, patients currently on Accutane, Isotretinoin, Sotret, Claravis, Amnesteem or who have been on Accutane, Isotretinoin, Sotret, Claravis, Amnesteem within in the last 3 months, and in many cases, patients who have tattoos in the area to be treated.

_____ 6. **Need for multiple treatments:** I understand that many conditions being treated by the LASER/IPL will require multiple treatments to obtain the desired results. For laser hair reduction, the procedure works by targeting growing hair follicles, not dormant hair. Complete destruction of all hair follicles with a single treatment is therefore not possible, and multiple treatments are necessary. For redness/rosacea, results are seen after the first treatment, but multiple treatments are often necessary to remove the desired amount of redness/blood vessels, and multiple treatments are often necessary to smooth a blotchy appearance that may be present after 1 treatment. Everyone responds in different ways and different rates to the treatment.

_____ 7. **Photographs:** I understand that the physician/technician may choose to take photos of my treatment area for the purpose of monitoring my progress.

_____ **8**. **For permanent hair reduction:** I understand that there are other options for permanent hair reduction such as electrolysis, waxing, and chemical preparations. I understand the difference between these options and permanent hair reduction, and I am choosing LASER/IPL as a noninvasive treatment for my hair epilation. I also understand that the hair follicles that are treated are permanently destroyed, and may not grow back (this is especially important when treating certain areas such as the neck, beard/ moustache area, scalp). Use of the laser is FDA cleared for permanent hair reduction, and it is possible that new hairs will grow at some point in the treated areas. Response to treatment varies from patient to patient.

_____ **9**. I understand that my insurance company will not cover the cost of laser therapy, and I am responsible for the complete cost of the service. Payment is due at the time of the treatment. I also understand that once I have started my treatment program, there are no refunds.

_____ 1**0**. I have received, read and understand the post-treatment instructions.

_____ 11. I agree to refrain from tanning or excessive sun exposure while I am undergoing treatment and 14 days after my treatment. I understand that direct sun exposure is prohibited while I am undergoing treatment and that the use of sun block protection with a minimum SPF 30 is mandatory.

I have been explained the nature and purpose of the LASER/IPL treatment, including any risks and possible complications, and has discussed the contents of this form with me. I have read and understand this consent form, and I agree to its terms and authorize treatment. I further understand that there are no guaranteed results. I will not hold April Marie Glow, LLC or the employees responsible for my individual results.

Patient name (Please Print): _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if under 18): _____ Date: _____