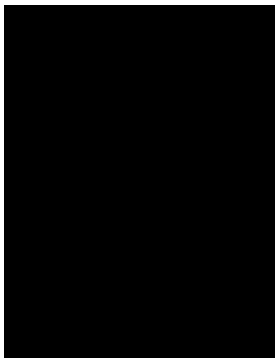

LASER HAIR REMOVAL TREATMENT CONSENT FORM

A Lowcountry Plastic Surgery Center Professional has explained to me the nature, goals, limitations and possible complications of this procedure and alternative forms of treatment. I have had the opportunity to ask questions about the procedure, its limitations and possible complications. These have been answered to my satisfaction.

I understand that all items contained herein apply to the following procedure(s): **Laser-Assisted Hair Removal** and **Intense Pulsed Light-Assisted Hair Removal.**

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

I clearly understand the following:

1. The potential benefits of the proposed procedure(s).

2. The possible alternative procedure(s).

3. The probability of success of my selected procedure.

4. The goal of Laser Hair Removal, as in any cosmetic procedure, is improvement, not perfection.

5. There is no guarantee that the expected or anticipated results from the treatments will be achieved.

6. For best results, I have been informed that multiple treatments are needed. More treatments may be needed depending on skin type, previous methods of hair removal, and hair color.

7. I must avoid tweezing, waxing, threading, and bleaching treatment areas.

8. Hormonal imbalance, pregnancy, and menopause can affect treatment outcomes.

9. Contraindictations for this procedure include:
    - □ Pregnancy and nursing
    - □ Accutane (must discontinue use of product 3 months before beginning treatment)
    - □ Epilepsy or those who have a history of seizures
    - □ Diabetes (no treatment below the ankles and no shaving)
    - □ Poorly controlled Diabetes
    - □ Current history of skin cancer, or current condition of any other type of cancer, or pre-malignant moles in area of treatment
    - □ Active sores or rash (psoriasis, eczema) in the area to be treated
    - □ Skin disorders such as keloids or abnormal wound healing
    - □ History of melanoma anywhere on the body
    - □ Recent (within 3 months) surgery, laser resurfacing or deep chemical peels in treatment area
    - □ Severe medical disorders such as poorly controlled heart conditions
    - □ Chemo or radiation therapy (letter of clearance from your physician is required)
    - □ Pacemaker, internal defibrillator, and any internal electrical devices
    - □ Any internal metal device, i.e. surgical screws, pins, plates, or implants, in the area to be treated (no treatment if the device is superficially in the body area to be treated)
    - □ AIDS, HIV positive or use of immunosuppressive drugs (a letter of clearance from your physician is required)
    - □ Multiple sclerosis (a letter of clearance from your physician is required with confirmation that the area to be treated is not numb)
    - □ Immune disorders such as: scleroderma, lupus, porphyria, sarcoidosis, and others
    - □ Children under the age of 12
    - □ Treatment over numbness of any body part
    - □ Treatment over moles or lesions of any kind
    - □ Treatment over tattoos, port wine stains, under the eyebrows, or any orifice
    - □ Use of photosensitive medications may cause increased sensitivity to the devices
    - □ Bleeding problems or use of blood thinners
    - □ Client Initial _____

10. Tanning during the course of my laser treatments is not recommended and can cause a number of complications. My scheduled treatment may be postponed if I am too tan.

11. I should avoid all tanning and sun exposure for 4 weeks before and 1 week after each treatment, as well as avoiding tanning beds.

12. I have been informed to use a sunblock with an SPF of 30 or higher on the treated area during the course of laser treatments.

13. It is my responsibility to inform the center if my skin is any darker than when I first started treatment.

14. It is my responsibility to inform the center of any medical or prescription changes.

15. Post-treatment care is very important and I will adhere to all the instructions given to me. Improper care to the treated area may increase the chances of any complications.

16. Laser Hair Removal can permanently reduce the numbers of hairs growing in the treated areas. Any remaining hair in general will be thinner and more easily treated by alternative methods.

17. The risks of this procedure include 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 increased susceptibility to sunburn and persistent pinkness for months.

18. There is a possibility that this procedure will be unsuccessful, need to be repeated, or may require additional treatment of complications.

19. Tattooed "permanent" makeup in the area to be treated with laser hair removal may darken, and there may be lightening of decorative tattoos.

20. I authorize the taking of photographs or videotapes, or other similar means of recording the treatment. I understand that these recordings may be used for publication, medical study, demonstration research and documentation of progress in my medical record. Failure to allow the taking of photographs of my treatment areas will make it impossible to judge the efficacy of my treatments and will void any extended treatment program, guaranty and/or any treatment due beyond those included in the purchased package.

21. I have been given copies of both pre and post care instructions.

22. I understand the procedure and accept the risks, and request that this procedure be performed by a provider at Lowcountry Plastic Surgery Center.

23. I have had sufficient opportunity to discuss my condition and treatment with the Lowcountry Plastic Surgery Center professional, and all my questions have been answered to my satisfaction. I believe I have adequate knowledge to understand the nature and risk of the treatment to which I am consenting.

I have read and understand all information presented to me before signing this consent form. I have had ample opportunity to ask any questions regarding laser hair removal, side effects, and after care.

Client/Guardian Signature _____ Date _____

Staff Signature _____ Date _____