



Consent for Cynosure Laser Hair Removal

I authorize The Plastic & Cosmetic center to perform laser hair removal on me. Treatment will be performed by trained staff under the direction of Dr. Thomas Jeneby, MD-Board Certified Plastic Surgeon.

I understand that the procedure is purely elective and the only indication is my request for treatment. I understand that insurance will not cover the procedure. For best results, I understand that multiple treatments will be necessary and these will incur additional costs.

I am aware of the following possible experiences/risks with Laser Surgery:

- ❖ _____ **DISCOMFORT** – Some discomfort may be experienced during laser treatment.
- ❖ _____ **WOUND HEALING** – Laser surgery can result in swelling, blistering, crusting, or flaking of the treated area. In which may require one to three weeks to heal. Once the surface has healed, it may be pink or sensitive to the sun for an additional two to four weeks, or longer in some patients.
- ❖ _____ **BRUISING/SWELLING/INFECTION** – With some lasers, bruising area may occur. of the treated Additionally, there may be some swelling noted. Finally, skin infection is a possibility although rare, whenever a skin procedure is performed.
- ❖ _____ **PIGMENT CHANGES (Skin Color)** – During the healing process, there may be a slight possibility that the treated area can become either lighter or darker in color. Compared to the surrounding skin, this is usually temporary, but on a rare occasion, it may be permanent.
- ❖ _____ **SCARRING** – Scarring is a rare occurrence, but it is a possibility when the skins surface is disrupted. To minimize the changes of scarring, it is **IMPORTANT** that you follow all post-treatment instructions carefully.
- ❖ _____ **EYE EXPOSURE** – Protective eyewear (shields) will be provided. It is important. to keep these shields on at all times during the treatment in order to protect your eyes from accidental laser exposure

Before and after treatment instructions have been discussed with me. The procedure as well as potential benefits and risks have been explained to my satisfaction. I have had all my questions answered. I freely consent to the proposed treatment and guarantee to make payment as agreed.

- ❖ _____ *******One treatment will be forfeited if a "NO SHOW" without a 24 hour notice of cancellation or rescheduling occurs for any voucher purchase.**

ACKNOWLEDGMENT:

I UNDERSTAND AND ACKNOWLEDGE THAT PAYMENTS FOR THE ABOVE PROCEDURE ARE NONREFUNDABLE. BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS PERMISSION FORM FOR LASER HAIR REMOVAL TREATMENT AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.

Signature-Patient or Guardian

Print Name/Relationship

Date:

Signature-Witness

Print Name/Relationship

Date:
