Bushra's Energy Spa

Laser Hair Removal Informed Consent Form

Full Name:_____

Date of Birth:_____ Age:_____

Cell Phone:_____ Home Phone:_____

Address:_____

Email:_____

Areas to be Treated:_____

Emergency Contact Name:_____

Emergency Contact Phone Number:_____

I fully understand that if I do not give a 48 hour notice to cancel or reschedule my appointment, that I will be charged $50.00._____ (Patient's initials)

Bushra's Energy Spa

Laser Hair Removal Informed Consent

I,_____, authorize laser technicians at Bushra's Energy Spa to perform Soprano ICE platinum laser hair removal procedures on my desired area of treatment.

I understand that the Soprano is a device used for laser hair removal and that clinical results may vary in different skin types and hair types. I understand there is a possibility of short-term effects such as reddening, blistering, scabbing, temporary bruising and temporary discoloration of skin, as well as rare side effects such as scarring and permanent discolouration. These effects have been fully explained to me. _____(patient's initials)

I understand that clinical results may vary depending on individual factors, including medical history and hormone imbalances, skin and hair type, patient compliance with pre/post treatment instructions, and individual response to treatment. _____ (patient's initials)

I understand that treatment by the Soprano laser hair removal system involves a series of treatments and the fee structure has been fully explained to me. _____(patient's initials)

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. _____ (patient's initials)

I can confirm that I am not pregnant or breastfeeding at this time._____(patient's initials)

I have not taken Accutane within the last 6 months. _____ (patient's initials)

I do not have a pacemaker or internal defibrillator. _____ (patient's initials)

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion. _____(patient's initials)

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Patient Signature:_____

Date:_____

Medical History

Please check mark the statements that apply to:

- ☐ Current or history of cancer within the past five years, especially malignant melanoma or recurrent non-melanoma skin cancer or precancerous lesions such as multiple dysplastic nevi.
- ☐ Any active infection.
- ☐ Diseases which may be stimulated by light at 515 nm to 1200 nm, such as history of recurrent Herpes Simplex, Systemic Lupus Erythematosus, or Porphyria.
- ☐ Use of photosensitive medication and/or herbs that may cause sensitivity to 515 - 1200 nm light exposure, such as Isotretinoin, tetracycline, or St John's Wort.
- ☐ Immunosuppressive diseases, including AIDS and HIV infection, or use of immunosuppressive medications.
- ☐ Patient history of hormonal or endocrine disorders, such as polycystic ovarian syndrome or diabetes mellitus, unless under control.
- ☐ History of bleeding coagulopathies, or use of anticoagulants.
- ☐ History of keloid scarring.
- ☐ Very dry skin.
- ☐ Exposure to sun or artificial tanning during the 3-4 weeks prior to treatment.

Please list any medical conditions (including pregnancy and/or breastfeeding) you have:

_____

_____

_____

Please list all medications and supplements (including herbal) you are taking:

_____

_____

_____

Skin Type (When exposed to the sun without protection for about 1 hour):

- ☐ Always burns, never tans
- ☐ Always burns, sometimes tans
- ☐ Sometimes burns, sometimes tans
- ☐ Always tans
- ☐ None of the above; please specify here:_____

What is your ethnic origin? (This information will allow your laser technician to accurately choose correct settings for your treatment sessions)

I Mr/Ms_____authorize:

Bushra's Energy Spa

To keep in the clinic my file and personal information (discretion applied)

I have read and understood this Laser Hair Removal Consent Form: My questions have been answered satisfactorily by the medical aesthetician or laser technician. I accept the risks and complications of the procedure.

_____	_____/_____/_____	_____
Patient Name (Please Print)	Date	Signature

_____	_____/_____/_____	_____
Medical Esthetician (Please Print)	Date	Signature

Patient Use Only

Appointment 1: I can confirm there have been no medical changes (including pregnancy) or medication changes as of the day of my laser hair removal procedure. _____(Patient Initials)
Date:_____/_____/_____

Appointment 2: I can confirm there have been no medical changes (including pregnancy) or medication changes as of the day of my laser hair removal procedure. _____(Patient Initials)
Date:_____/_____/_____

Appointment 3: I can confirm there have been no medical changes (including pregnancy) or medication changes as of the day of my laser hair removal procedure. _____(Patient Initials)
Date:_____/_____/_____

Appointment 4: I can confirm there have been no medical changes (including pregnancy) or medication changes as of the day of my laser hair removal procedure. _____(Patient Initials)
Date:_____/_____/_____

Appointment 5: I can confirm there have been no medical changes (including pregnancy) or medication changes as of the day of my laser hair removal procedure. _____(Patient Initials)
Date:_____/_____/_____

Appointment 6: I can confirm there have been no medical changes (including pregnancy) or medication changes as of the day of my laser hair removal procedure. _____(Patient Initials)
Date:_____/_____/_____

Appointment 7: I can confirm there have been no medical changes (including pregnancy) or medication changes as of the day of my laser hair removal procedure. _____(Patient Initials)
Date:_____/_____/_____

Appointment 8: I can confirm there have been no medical changes (including pregnancy) or medication changes as of the day of my laser hair removal procedure. _____(Patient Initials)
Date:_____/_____/_____

Technician Use Only

Skin Type:_____ Price per session:_____

Areas being treated:_____

Level Used:_____

Date:_____/_____/_____ Next appointment: _____/_____/_____

Skin Type:_____ Price per session:_____

Areas being treated:_____

Level Used:_____

Date:_____/_____/_____ Next appointment: _____/_____/_____

Skin Type:_____ Price per session:_____

Areas being treated:_____

Level Used:_____

Date:_____/_____/_____ Next appointment: _____/_____/_____

Skin Type:_____ Price per session:_____

Areas being treated:_____

Level Used:_____

Date:_____/_____/_____ Next appointment: _____/_____/_____

Technician Use Only

Skin Type:_____ Price per session:_____

Areas being treated:_____

Level Used:_____

Date:_____/_____/_____ Next appointment: _____/_____/_____

Skin Type:_____ Price per session:_____

Areas being treated:_____

Level Used:_____

Date:_____/_____/_____ Next appointment: _____/_____/_____

Skin Type:_____ Price per session:_____

Areas being treated:_____

Level Used:_____

Date:_____/_____/_____ Next appointment: _____/_____/_____

Skin Type:_____ Price per session:_____

Areas being treated:_____

Level Used:_____

Date:_____/_____/_____ Next appointment: _____/_____/_____