



Laser Hair Removal Consent/Office Policies

1. I, _____ consent to and authorize Dermatology Center of Williamsburg and members of their staff to perform multiple treatment laser-assisted hair reduction and related pre- and post treatment services on me.
2. The nature and purpose of the treatment have been explained to me and my questions I have regarding the treatment have been answered to my satisfaction.
3. I understand that the possible risks of the procedure include pain, swelling, redness, bruising, scarring, blistering, permanent lightening and darkening of the skin (which may occur months later) and unforeseen complications. Eye injury is possible but unlikely, providing complete eye protection is properly used thought laser treatment sessions. There is a rare possibility that a scar and/ or keloid at the treatment site may develop. I freely assume these risks.
4. I understand that multiple treatments will be necessary and that the laser does not always remove all unwanted hair.
5. No guarantee, warranty, or assurance has been made to me as to the results that may be obtained.
6. I understand that there are several alternatives to laser hair removal treatment including but not limited to electrolysis, shaving, waxing, and plucking or no treatment at all and that I have the right to refuse treatment.
7. I agree to adhere to all safety precautions and regulations during the laser treatments.
8. I certify that I am a competent adult of at least 18 years old; I understand that the consent of my parent/legal guardian will also be required before treatment if under the age of 18. I agree that any pictures taken of my treatment site may be used for publication or teaching purposes; however my name will not be disclosed and complete confidentiality will be maintained.

A specific appointment is reserved for your treatment. Please arrive fifteen minutes prior to your scheduled appointment in order for our staff to provide you with the treatment time required. Arriving late may reduce the length of your treatment or forfeit your entire appointment time to properly accommodate the next patient.

***We request a 24 hour advanced notice of any cancellations for appointments scheduled for less than 1 hour.
We request a 48 hour notice cancellations for appointments scheduled for more than one hour.***

Please leave a message on our answering service if after hours.

Because of safety regulations, children are not permitted in the laser treatment area. They should be supervised while in the reception area. As a courtesy to other patients and for you to receive your best treatment, we ask that you turn off all cell phones and pagers.

Printed Name of Patient _____

Date _____

Signature of Patient _____

Date _____

Signature of Witness _____

Date _____



Laser Hair Removal Patient Information/Medical Questionnaire

Client Name _____ Today's Date _____
Date of Birth _____ Age _____
Address _____
City _____ State _____ Zip Code _____
Home Phone(____) _____ Work Phone(____) _____ Cell(____) _____
Email _____
Employer _____ Occupation _____
Emergency Contact Name and Phone _____
Referred by _____
Have you ever had a laser hair removal treatment? { } Yes { } No, if yes When _____
Where _____ Location site _____
Please list your desired area of treatments _____

Which of the following best describes your skin type (please circle one skin type number)

- | | |
|--------------------------------|---------------------------------------|
| 1 Always burn, never tans | 4 Brown, Moderately pigmented skin |
| 2 Always burns, sometimes tans | 5 Rarely burns, always tans |
| 3 Sometimes burns, always tans | 6 Black skin, has never had a sunburn |

How do you heal? { } Fast healer { } Slow healer

Do you form thick or raised scars from cuts or burns? { } Yes { } No

Do you have hyperpigmentation (darkening of the skin) after physical trauma?

{ } Yes { } No *If yes please describe _____

Do you have hypopigmentation (lightening of the skin) after physical trauma?

{ } Yes { } No *If yes please describe _____

Do you have any tattoos or permanent make-up in the areas that we will be treating?

{ } Yes { } No *If yes please describe _____

Are you pregnant or trying to become pregnant? { } Yes { } No

Are you breastfeeding? { } Yes { } No

Do you have any of the following medical conditions? (Please check all that apply)

- Keloid scars Herpes Genital Herpes Frequent cold sores PCOS
 HIV/AIDS Hepatitis Diabetes High Blood Pressure Heart condition

Do you have any other health problems or medical conditions? Please list: _____

I certify the above information is true & correct. I am aware that it is my responsibility to inform the medical staff of my current medical or health conditions and to update this history is essential for the caregiver to execute appropriate treatment procedures.

Signature _____ Date _____

Laser Hair Removal Before And After Treatment

Prior to After Treatment

- No Tanning (self-tanner, tanning bed, etc.) 4 weeks prior to treatment.
- Do not pluck, wax, use a depilatory or undergo electrolysis in the areas you wish to have treated 6 weeks prior to treatment. Shaving is the fine.
- If you have a history of Herpes Simplex Virus or cold sores, you must pre-medicate one day prior to treatment to prevent further outbreaks.
- We will not be able to treat you if you have an active cold sore, if you have an outbreak please call our office and we will gladly reschedule your appointment.
- Please remove any make-up, lotion, body oil, perfume and jewelry prior to your appointment.

After Treatment

- Some redness and swelling the area is normal after treatment and may feel similar to a sunburn. This should resolve within several hours to several days after treatment.
- Applying ice packs or cool compresses will help with any discomfort.
- Gently clean area twice daily with a mild cleanser.
- Avoid irritants (glycolics, acids, retinoids, etc.) for 7 days after treatment.
- Apply sunscreen daily. It should be at least SPF 30 protects UVA/UVB and contains the physical blockers zinc oxide and titanium oxide. Our SkinCeuticles sunscreen contains all of the above. We will apply this to you before you leave our office.
- If needed, the only other acceptable hair removal method in between treatments is shaving.
- It may take 1-3 weeks for the dead hairs to shed out of the follicles.
- It is rare to develop blistering, if this happens, do not pop open the blister. Clean with a mixture of hydrogen peroxide diluted with ½ water. Then apply Bacitracin ointment or petroleum jelly and cover with a band aide or a non stick telpha pad and call our office so we can evaluate you.

If you have any questions or problems please call us at 757-645-3787