Laser Hair Removal

CONSULTATION FORM

CLIENT INFORMATION:

Name: _____ Date: _____

Date of birth: _____ Age: _____ ☐ Female ☐ Male ☐ Non-Binary

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about us? _____

Would you like to be added to our email list for news and exclusive offers? ☐ No ☐ Yes

MEDICAL HISTORY

Please mark any of the following conditions you may currently have.

- ☐ Acne
- ☐ Active Infection
- ☐ Anaphylaxis
- ☐ Arthritis
- ☐ Autoimmune Disease
- ☐ Bell's Palsy
- ☐ Bleeding Disorders
- ☐ Breathing Problems/Disease
- ☐ Cold Sores (HSV1)
- ☐ Liver/Kidney Dysfunction
- ☐ Diabetes
- ☐ Eczema/Rashes
- ☐ Epilepsy/Seizures
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes (HSV2)
- ☐ Hirsutism
- ☐ HIV/AIDS
- ☐ Hypo/Hyper Pigmentation
- ☐ Hysterectomy
- ☐ Implantable Defibrillator
- ☐ Irregular Periods
- ☐ Keloid Scarring
- ☐ Low/High Blood Pressure
- ☐ Menopause
- ☐ Multiple Sclerosis/ALS
- ☐ Lesions, Open wounds
- ☐ Lupus
- ☐ Pacemaker
- ☐ Photosensitivity
- ☐ Polycystic Ovaries
- ☐ Poor Blood Circulations
- ☐ Pregnant
- ☐ Psoriasis
- ☐ Shingles
- ☐ Skin Cancer
- ☐ Thyroid Imbalance
- ☐ Vitiligo
- ☐ Warts

Any other condition? _____

LASER HAIR REMOVAL CONSULTATION FORM

Are you currently under a doctor's care? ☐ No ☐ Yes
If yes, please explain: _____

Have you ever been treated for cancer? ☐ No ☐ Yes
If yes, please explain: _____

Do you have any implants? ☐ No ☐ Yes
If yes, please explain: _____

Have you ever been treated with hormone medication? ☐ No ☐ Yes
If yes, please explain: _____

Have you had any severe reactions to histamines? ☐ No ☐ Yes
If yes, please explain: _____

Any previous surgeries? ☐ No ☐ Yes
If yes, please explain: _____

Do you have any allergies? ☐ No ☐ Yes
If yes, please list all: _____

List all medications you take, including vitamins, herbal supplements, aspirin, hormones and topical:

_____

When is your next menstrual cycle due to begin? _____

(For your comfort, allow five days for your menstrual cycle. Avoid hair removal two days before your cycle is due and two days after it is completed.)

Are you pregnant, trying to become pregnant or nursing? ☐ No ☐ Yes

SKIN HISTORY

Have you taken Accutane or Immunosuppressants in the past 6 months? ☐ No ☐ Yes
Have you used Retin-A, Retinol, AHA, or acid-containing products in the past 7 days? ☐ No ☐ Yes
Do you use any other products or drugs that cause photosensitivity? ☐ No ☐ Yes
Are you regularly exposed to the sun on a daily basis? ☐ No ☐ Yes
Do you currently have a sunburn? ☐ No ☐ Yes
Does your skin tend to become blotchy, red, or easily irritated? ☐ No ☐ Yes
Are you planning to spend an extended amount of time in the sun soon? ☐ No ☐ Yes
Have you recently used a tanning bed, tanning lotions, or received a spray tan? ☐ No ☐ Yes
Have you recently undergone chemical peels, glycolic peels, or laser resurfacing? ☐ No ☐ Yes
Is your skin sensitive to soaps, lotions, hydroquinone, or skin bleaching agents? ☐ No ☐ Yes
Have you had a tattoo or permanent makeup in the area(s) to be treated? ☐ No ☐ Yes
In the past 6 months, have you received Botox or fillers in the area(s) to be treated? ☐ No ☐ Yes

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LASER HAIR REMOVAL CONSULTATION FORM

Are you currently under a doctor's care? _____

Do you have any abrasions, moles or skin irritations in the area(s) to be treated?

_____

Please list any skin care products you currently use:

_____

Have you had your hair professionally removed before? ☐ No ☐ Yes

If yes, please list areas, methods used and date last removed:

_____

_____

WHAT SERVICE WOULD YPU LIKE

Face:

- ☐ Brow
- ☐ Lip
- ☐ Chin
- ☐ Full face
- ☐ Side bums

Upper body:

- ☐ Full arms
- ☐ Half arms
- ☐ Under arms
- ☐ Back/shoulder
- ☐ Abdomen
- ☐ Chest

Lower body:

- ☐ Full legs
- ☐ Half legs
- ☐ Brazilian
- ☐ Bikini

Other:

- ☐ Full body
- ☐ Other: _____

By signing below, you agree to the following:

I have completed this form truthfully and to the best of my knowledge. I agree to waive all liabilities toward my technician and the employer for any injury or damages incurred due to any falsification of my medical history

_____ Client Name (Printed)

_____ Client Name (signature)

_____ Date

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Laser Hair Removal

INFORMED CONSENT

INSTRUCTIONS

I understand that this document provides information regarding laser procedures, including their risks and potential alternative treatments. I acknowledge the importance of reading this information carefully and thoroughly. I will initial each page to indicate that I have read it, and I will sign the consent for treatment.

GENERAL INFORMATION

Laser hair reduction is a highly effective method for achieving long-lasting hair removal results that surpass those of traditional shaving or waxing. By targeting the hair follicles beneath the skin's surface, the laser destroys the follicles while leaving the surrounding skin unharmed. This treatment can be performed on various areas of the body, including the face, bikini area, legs, arms, chest, and back, resulting in smooth and stubble-free skin without the hassle of ingrown hairs. The procedure is relatively quick, typically taking an hour or less, and most patients experience minimal discomfort. There is no downtime associated with this procedure.

It's important to note that hair grows in cycles, and laser hair removal is most effective during the active growth phase. For this reason, multiple sessions are required to achieve optimal results. After each treatment, you will notice a significant reduction in visible hair. With each subsequent treatment, hair will grow back progressively slower, lighter, and finer. It usually takes more than one treatment to target all the follicles in a specific area.

The number of sessions needed will vary for each individual. During the initial visit, the laser will disable the follicles in the active growth phase, but dormant follicles will not be affected. As dormant follicles become active, additional sessions may be necessary to target them. On average, most people achieve satisfactory clearance after four to six treatments, although individual results may vary depending on factors such as medical history and genetics. It's important to note that lighter colored hair may require more treatments compared to darker colored hair.

While laser hair reduction can offer a significant reduction in hair growth, it does not guarantee permanent hair removal. On average, patients can expect a 60% to 70% reduction in hair growth.

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ALTERNATIVE TREATMENTS

Yes, alternative forms of hair removal treatment include shaving, waxing, electrolysis, and choosing not to undergo laser hair reduction procedures.

IMPORTANT INSTRUCTIONS. PLEASE READ FOR YOUR PROTECTION

If you are unsure whether a product you are using may be a contraindication to your laser hair removal sessions, it is indeed recommended to confirm with your primary physician prior to your appointment day.

PRE-TREATMENT: Laser Hair Removal

- **Avoid sun exposure for 2-4 weeks before and after the treatment.**
- **Completely remove any spray tan using an alcohol wipe before the treatment.**
- **Do not use tanning lotions, tanning beds, tanning sprays, or tanning solutions during the treatment.**
- **Cover all treated areas and use sunscreen with an SPF of 30 or higher.**
- **Avoid taking antibiotics for a minimum of 14 days before and after the treatment.**
- **Avoid taking Aspirin or blood thinning medications for a minimum of 14 days before the treatment.**
- **Do not use Retin-A, Retinol, Benzoyl Peroxide, Niacinimide, Salicylic acid, Hyaluronic acid, or other acid-containing products for a minimum of 7 days before the treatment.**
- **Do not use Accutane or Immunosuppressants for a minimum of 6 months before the treatment.**
- **Avoid facial treatments, microdermabrasion, or chemical peels for a minimum of 14 days before the treatment.**
- **Arrive to the treatment clean and free of makeup, deodorant, lotion, and ointments.**
- **Shave the treated areas 24-48 hours prior to the appointment, but do not wax, pluck, tweeze, thread, or bleach.**
- **Inform the technician about any medical conditions or history, including heart disease, thyroid issues, diabetes, cancer, skin diseases, or any other relevant conditions.**
- **You may NOT have any type of laser treatment if you are (or think you may be) pregnant or nursing.**

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POST-TREATMENT: Laser Hair Removal

Immediately after treatment:

- Expect redness and bumps, which may last up to 2 hours or longer.
- The treated area may feel like sunburn for a few hours.
- Allergic reactions such as swelling, itching, and hives are common. Antihistamines, hydrocortisone, or Benadryl can be used.

Sun protection:

- Apply sunblock with an SPF of 30 or higher several times daily, especially when spending time outdoors.
- Improper use of sunblock may cause hyperpigmentation, which can last several months to years.
- Avoid sun exposure, tanning lotions, tanning beds, tanning sprays, and tanning solutions for 2-4 weeks after treatment.

General care:

- Avoid picking or scratching the treated skin.
- Shedding of hair may occur 5-30 days after treatment, appearing as new hair growth. It is dead hair pushing out of the follicle.
- Do not use other hair removal methods or products on the treated area during the course of your laser treatments, except shaving if needed between sessions.
- Makeup can be used 24 hours after treatment unless there is epidermal blistering. It's recommended to use new makeup to reduce the risk of infection.
- Avoid exercising, using deodorant, Jacuzzis, saunas, steam rooms, and hot showers for 24 hours post-treatment.
- Do not receive facial treatments, microdermabrasion, or chemical peels for a minimum of 14 days after laser treatment.

Hair regrowth and follow-up:

- Hair regrowth occurs at different rates on different areas of the body.
- True results will be seen gradually as laser hair removal is a treatment process.
- The recommended return time for laser hair removal is between 4-6 weeks.
- Contact your physician's office if you have any questions or concerns after the treatment.

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RISKS

It's important to understand the risks and potential complications associated with any procedure. Here are some common risks and complications that can be associated with various treatments:

Burns: Laser energy can produce burns. Additional treatment may be necessary to treat laser burns.

Skin irritation or redness: Following treatment, you may experience temporary skin irritation, redness, or sensitivity in the treated area. This is typically mild and resolves on its own within a few days.

Swelling: Some treatments may cause temporary swelling in the treated area. This is usually a normal response and will subside over time.

Discomfort or pain: Depending on the type of procedure, you may experience some level of discomfort or pain during or after the treatment. This can usually be managed with over-the-counter pain relievers or prescribed medications, if necessary.

Bruising or bleeding: In some cases, bruising or minor bleeding may occur at the treatment site. This is usually temporary and resolves on its own.

Infection: Although rare, there is a risk of infection following any invasive procedure. It's important to follow proper post-treatment care instructions and keep the treated area clean to minimize this risk.

Scarring: Certain procedures carry a risk of scarring, especially if they involve incisions or tissue manipulation. Your healthcare provider should discuss the risk of scarring with you before the procedure.

Changes in skin pigmentation: Some treatments may cause temporary or permanent changes in skin pigmentation, such as hyperpigmentation (darkening of the skin) or hypopigmentation (lightening of the skin). These changes are usually temporary but, in rare cases, may be permanent.

Visible Skin Patterns: Laser procedures may produce visible patterns within the skin. The occurrence of this is not predictable.

Allergic reactions: There is a risk of allergic reactions to certain products or medications used during or after the procedure. It's important to inform your healthcare provider about any known allergies or sensitivities you have.

Unsatisfactory results: While the goal of any procedure is to achieve

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ADDITIONAL TREATMENT NECESSARY

The outcome of a laser procedure can be influenced by various factors, including individual healing capabilities, pre-existing medical conditions, and adherence to pre and post-procedure instructions. While good results are typically expected, it's important to understand that there are no guarantees or warranties expressed or implied regarding the specific results of the procedure.

In the event that complications do occur, additional treatments or surgeries may be necessary to address them. It's crucial to have open and honest communication with your healthcare provider, discuss any concerns or questions you may have, and follow their guidance throughout the process to minimize the risks and maximize the potential benefits of the procedure.

PATIENT COMPLIANCE

Following the postoperative instructions provided by your physician is crucial for ensuring the success of your outcome and minimizing the risk of complications. These instructions may include restrictions on certain activities, proper dressing care, and the use of sun protection, among other things.

By adhering to these instructions, you can help promote proper healing, reduce the risk of infection or other complications, and optimize your recovery process. It's important to take these instructions seriously and not hesitate to reach out to your physician if you have any questions or concerns during your recovery.

FINANCIAL RESPONSIBILITIES

By acknowledging and accepting responsibility for the clinical decisions made and the financial costs of future treatments, you are demonstrating your understanding of the risks and consequences associated with the procedure. It is important to be fully informed about the potential risks, outcomes, and financial implications before undergoing any medical or cosmetic procedure.

DISCLAIMER

Informed consent documents serve as a means to communicate important information about the proposed treatment, including risks and alternatives, to patients. They are designed to provide a general understanding of the treatment and its associated risks and complications.

However, it's important to note that informed consent documents cannot cover every possible scenario or individualized circumstances. Each patient is unique, and there may be specific factors or considerations that are relevant to your case, which may not be covered in the general consent document.

Your healthcare provider will take into account your specific medical history, current condition, and any other relevant factors to provide you with additional or different information that is tailored to your individual situation. They will address any specific concerns or questions you may have and ensure that you have a comprehensive understanding of the treatment and its potential risks.

The informed consent process is an ongoing dialogue between you and your healthcare provider, and it's important to actively participate, ask questions, and seek clarification on any aspects that are not clear to you. This will ensure that you have a complete understanding of the proposed treatment and can make an informed decision regarding your care.

Client Initials:_____

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ACKNOWLEDGEMENT

I acknowledge that the information on this Laser Hair Removal Informed Consent Form is essential to my medical and cosmetic condition and the success of my treatments. I have been informed and understand that no guarantees can be or have been made concerning the expected results. I understand that even though complications from laser hair removal are rare, it can and sometimes do occur. I understand clinical results may vary from patient to patient. Multiple treatments or additional touch-ups may be necessary to achieve desired results.

As I am fully aware of the risks that may be associated with laser hair removal, I will not hold [YOUR COMPANY NAME HERE], and their associates responsible for any risks associated with their provided treatments. I also understand that [YOUR COMPANY NAME HERE], and any of their associates have the right to refuse service to me anyone. I fully accept responsibility for any complications that may occur and thereby absolve [YOUR COMPANY NAME HERE], and all of their associates of any blame resulting therefrom.

I understand that all contents of these forms are subject to change at any time by [YOUR COMPANY NAME HERE], and any of their associates without further notice. While informed consent documents may provide information about the risks, benefits, and alternatives associated with a particular treatment or procedure, they do not establish the standard of care. Medical professionals must consider a variety of factors, including the individual circumstances of each case, when determining the appropriate course of treatment.

By signing below, I hereby acknowledge that I have read and understand all the information in this informed consent agreement. I understand that this agreement is legal and binding and will remain in effect for this procedure and all future follow-ups conducted by [YOUR COMPANY NAME HERE], and any of their associates. I fully understand the risks and side effects associated with the treatment. I freely assume these risks and release [YOUR COMPANY NAME HERE], and any of their associates of all liability.

_____	_____	_____
Client Name (printed)	**Client Name (signature)**	**Date**

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Laser Hair Removal

CLIENT CONSENT FORM

CLIENT FULL NAME: _____

It is important to have a clear understanding of the process and expected outcomes of laser hair removal. Your statement accurately reflects the nature of the treatment. Laser hair removal targets actively growing hairs, and multiple sessions are typically required to achieve significant and long-term reduction of hair growth. It is also important to note that individual results may vary, and some people may not experience complete hair loss even with multiple treatments. Maintenance treatments may be necessary to maintain the desired results. It is important to discuss any concerns or questions you may have with the professionals at [YOUR COMPANY NAME HERE] to ensure a comprehensive understanding of the procedure.

Please initial each statement:

_____ **The potential benefits of the proposed procedure.**

_____ **Possible alternative procedures.**

_____ **The probability of success.**

_____ **Possible risks and complications involved with the proposed procedure and subsequent healing period, including, but not limited to infection, scarring, crusting, regrowth of hair, and/or blistering.**

_____ **Pre and Post treatment instructions.**

Please initial to acknowledge that you are aware of the following possible experiences/complications/risks with the Laser Treatment:

_____ **Discomfort – May be experienced during laser treatment.**

_____ **Healing – Laser hair removal can result in swelling, blistering, crusting, or flaking of the treated areas. This may take 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 - After laser treatment, bruising or swelling can occur. Additionally, although rare, skin infections can also occur.**

_____ **Pigmentation change** - In some cases, the treated area may become darker than the surrounding skin. This is known as hyperpigmentation and is more common in individuals with darker skin tones. Hyperpigmentation usually fades over time, but it may take several weeks or months for the skin to return to its normal color.

_____ **Scarring**- is a potential risk associated with laser hair removal, although it is rare. Whenever the skin's surface is disrupted, there is a possibility of scarring. Therefore, it is important to follow pre and post-treatment instructions carefully to minimize damage.

_____ **Eye exposure** – It is important to wear protective eyewear (shields) during the treatment in order to protect your eyes from accidental laser exposure.

_____ I acknowledge that the laser treatment is **NOT** appropriate for individuals who:

- Are pregnant or breastfeeding
- Are prone to keloid formation.
- Have a history of poor wound healing
- Are taking medication that creates light sensitivity
- Are taking anti-seizure medication.
- Are hypersensitive to light.
- Have a personal or family history of skin cancer.
- Have undiagnosed lesions.
- Had a recent herpetic outbreak.
- Have unstable diabetes or an autoimmune disorder.
- Have a photosensitive skin disorder.

By signing below, I hereby acknowledge that I have read and fully understand all the information in this consent agreement. I agree to receive the laser treatment or series of laser treatments and I will adhere to all of the aforementioned statements that I have initialed. I understand that this consent agreement is legal and binding and will remain in effect for this procedure and all future follow-ups conducted by [YOUR COMPANY NAME HERE], and any of their associates. I fully understand the risks and side effects associated with the treatment. I freely assume these risks and release [YOUR COMPANY NAME HERE], and any of their associates of all liability.

_____	_____	_____
Client Name (printed)	Client Name (signature)	Date

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Laser Hair Removal

CLIENT TREATMENT RECORD

CLIENT INFORMATION:

Name: _____ Date: _____

Date of birth: _____ Age: _____ ☐ Female ☐ Male ☐ Non-Binary

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

DATE	AREA TREATED	SETTINGS USED	NOTES	PRICE

FITZPATRICK ASSESSMENT

Client Name: _____ Date: _____

ANALYSIS	0	1	2	3	4	SCORE
Natural eye color?	Light blue, gray or green	Blue, gray or green	Blue	Dark brown	Brownish black	
Natural hair color? (prior to grey)	Sandy red	Blond	Chestnut, dark blond	Dark brown	Black	
Skin color? (non-exposed)	Reddish	Very pale	Pale with beige tint	Light brown	Dark brown	
Freckles on unexposed areas?	Many	Several	Few	Incidental	None	

GENETIC DISPOSITION TOTAL: _____

ANALYSIS	0	1	2	3	4	SCORE
What happens when you stay in the sun too long?	Painful redness, blistering, peeling	Blistering followed by peeling	Burns sometimes followed by peeling	Rarely burns	Never had burns	
To what degree to you turn brown?	Hardly or not at all	Light color tan	Reasonable tan	Tan very easily	Turn dark brown quickly	
Do you turn brown within several hours after sun exposure?	Never	Seldom	Sometimes	Often	Always	
How does your face react to the sun?	Very sensitive	Sensitive	Normal	Very resistant	Never had a problem	

REACTION TO SUN EXPOSURE TOTAL: _____

ANALYSIS	0	1	2	3	4	SCORE
When did you last expose your body to sun, tanning bed or cream?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago	
Was the area to be treated exposed to the sun, tanning bed or cream?	Never	Hardly ever	Sometimes	Often	Always	

TANNING HABITS TOTAL: _____

SKIN TYPE SCORE	FITZPATRICK SKIN TYPE
0-7	I
8-16	II
17-25	III
25-30	IV
Over 30	V

TOTAL SKIN TYPE SCORE:	
FITZPATRICK SKIN TYPE	

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Laser Hair Removal

PHOTO & VIDEO RELEASE FORM

I, _____ hereby grant and authorize _the practitioner at Ageless Med Spa LLC I grant the right to capture, modify, edit, reproduce, exhibit, publish, distribute, and utilize any photographs, videos, and/or audio recordings taken of me for lawful promotional purposes. These materials may include, but are not limited to, newspapers, flyers, posters, brochures, advertisements, press kits, websites, social media platforms, and other forms of print and digital communication. I provide this authorization without expecting any payment or other forms of consideration.

This authorization remains in effect indefinitely and applies to all languages, media, formats, and markets, whether currently known or discovered in the future.

I willingly waive any rights to royalties or other compensation arising from or related to the use of these photographs or recordings.

I acknowledge and accept that the materials created through this agreement will be the property of the Ageless Med Spa LLC and will not be returned to me.

I hereby release and discharge the treating practitioner at Ageless Med Spa LLC from any liability, claims, or legal actions that may arise, including those made by myself, my heirs, representatives, executors, administrators, or any other individuals acting on my behalf or on behalf of my estate.

By signing below, I confirm that I have thoroughly read and comprehended the entirety of the release agreement stated above.

By signing below, I hereby acknowledge that I have completely read and fully understand the above release agreement

_____	_____	_____
Client Name (Printed)	Client (signature)	Date

Laser Hair Removal

CANCELLATION POLICY

In order to ensure the provision of high-quality care within a reasonable timeframe, we have implemented an appointment and cancellation policy.

As appointments are in high demand, canceling your appointment in advance allows us to offer the time slot to another individual seeking timely care. This policy helps us optimize our appointment availability for all clients.

During the appointment booking process, you will be required to make a _10%_ deposit, which will be applied as a credit towards your scheduled treatments.

We understand that circumstances may arise requiring you to cancel or reschedule your appointment. To avoid any inconvenience, please notify us at least 24 hours prior to your scheduled appointment. In such cases, your deposit will either be refunded or applied towards a future appointment. However, if you provide less than 24 hours' notice, a _$100_cancellation fee will be charged.

Please note that if you arrive more than _10_ minutes late for your appointment, it will be considered a no-show and the cancellation fee will be applied.

We are more than happy to address any inquiries or concerns you may have regarding our cancellation policy.

I have read and fully understand the above Appointment Cancellation Policy and agree to be bound by its terms. I agree to pay the cancellation fee in the event of a missed appointment.

Client Name (Printed)	Client (signature)	Date

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