



www.novamedspa.com

21785 Filigree Court, Suite 100 Ashburn, Virginia 20147 703.554.1130 fax: 703.554.1133

## GentleLase Hair Removal Consent Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  Female  Male

Contact Phone Numbers:

(H): \_\_\_\_\_ (W): \_\_\_\_\_ (C): \_\_\_\_\_

Are You pregnant?  Yes  No

**Skin Type (I-IV):**  Fair  Olive  Dark  Asian / Hispanic  Black

**Hair Type:**  Coarse  Fine Comments: \_\_\_\_\_

**Hair Color:**  Black  Brown  Red  Blonde  Gray  Other

**Allergies:** \_\_\_\_\_

Are you currently taking any medications?

*(Please list if any, Accutane, Aspirin, Antiviral, Coumadin, Photosensitivity drugs such as St. John's Wort)*

Present Illnesses:

History of keloids / hypertrophic scars:

Other / Tanning history:

Area(s) to be treated:

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Previous treatment (specify date / year, number of treatments, frequency, tissue response)

Wax epilation: \_\_\_\_\_

Mechanical epilation: \_\_\_\_\_

Electrolysis: \_\_\_\_\_

Bleaching: \_\_\_\_\_

Previous Laser treatment: \_\_\_\_\_

Frequency of tweezing area: \_\_\_\_\_

Other treatments: \_\_\_\_\_

**Recommendations:**

*\*\*\*After Reviewing the recommendations, please have client initial each item\*\*\**

1. \_\_\_\_ Discuss treatment options (*testing, color of hair responds best, number of treatments*)
2. \_\_\_\_ Discuss client expectations: understand need for multiple treatments, after care, possible side effects, etc.
3. \_\_\_\_ Review in detail full treatment schedule process (waiting period, when to expect re-growth, shaving ONLY 6 weeks prior to/after treatment)
4. \_\_\_\_ Discuss possible side effects (hyper pigmentation, hypo pigmentation, purpura, scaring) and length of time to expect healing if side effects occur.
5. \_\_\_\_ Discuss specifics of area to be treated, test small area for tissue response BEFORE full treatment, client should not eat gas causing foods if treating anal area (provider should protect eyes/brow, nose, ears when treating).
6. \_\_\_\_ Discuss avoidance of sun exposure and the use of sunscreen during entire program.
7. \_\_\_\_ Discuss sensation of the laser/DCD spray and the option for topical anesthesia.
8. \_\_\_\_ Discuss benefits of laser treatment, possible long-term hair removal, and laser safety.
9. \_\_\_\_ Discuss cost (payment schedule, cost of multiple versus single payment per visit).

**Comments:**

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**Consent Agreement**

I agree that the information listed above has been reviewed and presented with my clear understanding of what this procedure involves. All of my questions have been addressed to my satisfaction.

Clients Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clients Name \_\_\_\_\_

*(Please Print)*

Providers Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Providers Name \_\_\_\_\_

*(Please Print)*



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## **Laser Hair Removal Pre & Post Treatment Care**

### **Avoid any of these medications or treatments:**

1. Area to be treated should be shaven within 24 hours of treatment for optimal results.
2. Accutane 1 year prior to the treatment. It should be discontinued for the duration of your series.
3. Any type of Chemical Peel 2 - 4 weeks prior and after the treatment on the area to be treated.
4. Retin-A, Renova and Tazorac 2 weeks prior and after to the treatment.
5. Sun exposure or usage of a tanning bed 2 weeks prior and after the treatment
6. Waxing on the area to be treated 3 weeks before the treatment and for the duration of your series.

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## Laser Hair Removal Consent Form

The procedure planned is laser-assisted hair removal using either the Candela or Gentle Lase.

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

I understand that the risks of this procedure include possible 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 increase susceptibility to sunburn or persistent pinkness for months.

I understand that there is a possibility that this procedure will fail, be unsuccessful, need to be repeated, or may require additional treatment of complications. If tattooed "permanent" make up or a "decorative" tattoo is in the area to be treated with laser hair removal, lightening of decorative tattoos, or blackening of makeup tattooing can occur.

I understand my responsibility for properly fulfilling the appropriate aftercare instructions as it is explained by a certified Aesthetician at *The Medical Spa at Nova*.

Although part or all the cost for this procedure may, in rare situations, be reimbursed by insurance companies, many policies/companies consider this procedure cosmetic or not covered for various other reasons. I understand that I am responsible for all costs whether or not covered by my insurance.

I have been asked at this time whether I have any questions about this procedure, and I do not. I have complete understanding of both pre and post care instructions. I understand the procedure and accept the risks, and request that this procedure be performed by a provider at *The Medical Spa at Nova*.

Clients Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clients Name \_\_\_\_\_

(Please Print)

Providers Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Providers Name \_\_\_\_\_

(Please Print)

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