**Laser Hair Reduction CONSENT FORM**

In signing this document, I give permission to the clinic staff of Cheeky Medspa perform laser hair reduction.

I understand that the goal of this procedure is the gradual permanent reduction of my hair. I understand that every individual is unique, and it is very difficult to guarantee a specific number of treatments need- ed. It is expected that I will require at least six treatments for the body and six to eight treatments for the face, give or take one treatment. \_\_\_\_\_ **initials**

I agree to call the clinic if I have any difficulty after my treatment. The number to call is: 907-252-3198 (Cheeky Medspa). \_\_\_\_\_ **initials**

I acknowledge that I have not waxed the treated area within the previous six weeks nor have I plucked the hair from the area being treated**. I acknowledge that I have not been sun tanning for the previous FOUR weeks.** \_\_\_\_\_ **initials**

Although uncommon, I understand that complications can occur. It has been explained to me that these complications include: a sunburn feeling, redness, local tenderness and mild swelling, occasionally blistering, very rarely pigmentation changes and scarring. \_\_\_\_\_ **initials**

I understand that how I take care of my skin after treatment influences my risk of complications. I agree to wash my skin gently twice-daily and apply an antibacterial cream for the first week**. I agree to stay out of the sun or to use sufficient sun block for FOUR weeks following my treatment**. I agree to call the clinic if I develop any markings on my skin after treatment, and I will not pick at them. \_\_\_\_\_ **initials**

I have not taken Accutane within the last 12 months. \_\_\_\_\_ **initials**

I am not currently pregnant. \_\_\_\_\_ **initials**

I am a not allergic to topical anesthetics (topical freezing). \_\_\_\_\_ **initials**

If I have forgotten to tell the clinic staff of my health problems, medications, allergies, or other important information about me, I will do so now. I will inform the doctor if I become pregnant. \_\_\_\_\_ **initials**

I hereby give my permission to undergo laser hair Reduction and verify all above information has not changed since previous treatment here at Cheeky Medspa.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

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Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_