INFORMED CONSENT FORM: LASER/LIGHT BASED TREATMENT

I authorize Skin Dermatology to perform LightSheer® DESIRE treatments on me in an effort to improve Hair Reduction/ Pseudo folliculitis Barbae.

I understand that:

- There is a rare possibility of side effects or serious complications including permanent discoloration and scarring. I am aware that careful adherence to all advised instructions will help reduce this possibility
- Sun exposure or tanning of any sort is not aligned with the pre and/or post-care instructions and may increase the chance for complications

I understand the below list of short-term effects and agree to follow matching guidelines:

- Discomfort – during the procedure and shortly after, I might experience an itching sensation which degree will vary per hair density, area sensitivity and treatment head used but that does not last long. A mild "sun-burn" sensation may follow for typically up to one hour and will be reduced with application of cooling and soothing creams
- Perifollicular erythema/oedema – severity and duration of the rash depend on the intensity of the treatment and the sensitivity of the area to be treated. These phenomena may be reduced with application of cooling and/or inflammatory creams
- Micro-crusting over some areas with very dense and coarse hair – may take 5 to 10 days to flake off and it is important not to manipulate or pick which may otherwise lead to scarring
- Bruising may rarely occur and may last several days

I understand that I should call my provider as soon as possible if I have any concerns about side effects or complications after treatment.

By signing I certify that I have provided accurate information as to my health condition to Skin Dermatology. I consent to photographs being taken for the purpose of documenting my progress and response to the treatment and be kept solely in my medical record unless a Photography Consent is obtained.

The procedure as well as potential benefits, risks and alternative treatment options have been thoroughly explained to me and I have had all my related questions answered. Before and after treatment instructions have been discussed with me.

I understand that the practice of medicine is not an exact science and no results have been guaranteed. I acknowledge that the results may not meet my expectations. I certify that no guarantees have been made by anyone regarding the procedure(s) that I have requested and authorized. I understand that results may vary with each individual and acknowledge that it is impossible to predict how I will respond to the treatment and how many sessions will be required

I CERTIFY THAT I HAVE READ, FULLY UNDERSTOOD AND RECEIVED A COPY OF THE ABOVE CONSENT AND THAT I HAVE RECEIVED CLEAR EXPLANATIONS REGARDING THE PROVIDED INFORMATION.

I have read and understand all information presented to me before consenting to treatment. I have had all my questions answered.

Client*:______________________________________ Date ______________________________

Witness:______________________________________ Date ______________________________

* Parent or legal guardian if patient is under age 18 or unable to authorize consent.