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A Medical Corporation

Dermatology & Dermatologic Surgery
Cosmetic & Laser Surgery

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LASER-ASSISTED HAIR REMOVAL: INFORMED CONSENT

I, _____, hereby give my consent to and authorize Dr. Roberts or _____ M.D. to perform laser-assisted hair removal treatments on my _____.

The nature and purpose of the laser treatments have been explained to me, and any questions that I have regarding the treatment have been answered to my satisfaction. I understand that it may not be possible to totally eliminate my unwanted hair with the laser treatment.

I understand that the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume these risks. These risks include, but are not limited to, the following:

1. Skin burns – blistering, crusting, or scabbing
2. Temporary redness (pink “goose flesh”) and swelling in the treated area. (This actually indicates a successful treatment was performed and usually subsides within 24 hours.)
3. Changes in skin color (white or brown spots, including white imprints which may be permanent)
4. Pain during the procedure. (Mild burning and stinging may last for 24 hours after the procedure.)
5. Superficial skin infection.
6. Folliculitis from ingrown hairs
7. Allergic reaction to the topical solution or product used on the skin.
8. Rare reports of scarring which may be permanent.
9. Incomplete removal of hair necessitating further treatment.
10. Whitening of previously dark hair may rarely occur and does not respond to further laser treatments.

I agree to avoid sun exposure and tanning for at least 4-6 weeks before, during and after laser treatments. I have been informed that treatment will not be done on tanned skin.

I have been informed that white, blonde or gray hair will not be affected appreciably.

I agree to avoid electrolysis and waxing at least 6 weeks before and between laser treatments.

I understand this procedure is considered cosmetic and will not be covered by my health insurance. This office will not bill my insurance for this treatment. My insurance may or may not cover treatment if any complications should arise. Initial_____

Alternative treatments include, but are not limited to shaving, waxing, electrolysis, threading chemical depilatory creams, bleaching and no treatment.

I ACKNOWLEDGE THAT NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME CONCERNING THE OUTCOME OF LASER SURGERY. Initial_____

The effect, nature, risks, benefits, limitations and alternatives of laser hair removal have been fully explained to my complete satisfaction. I have had sufficient opportunity to discuss my condition with Dr. Roberts and all of my questions have been answered to my satisfaction. Initial_____

I fully understand that the success or failure of the operation in part depends upon my assuming responsibility in my post-operative care. Initial_____

My signature certifies that I have read and understand this entire consent and discussed all of the above material thoroughly with Dr. Roberts, and that I understand the goals, limitations and possible complications of laser hair removal, and that I wish to proceed with the procedure.

I freely and voluntarily give my consent for laser hair removal.

Patient Signature_____ Date_____

Guardian Signature (if patient is a minor)_____

Relationship to patient_____

Witness Signature_____ Date_____