



Laser Hair Removal Patient Consent Form

PRINTED NAME: _____ D.O.B: _____

I authorize Wilmington Dermatology Center to perform **Motus AX** on me today. I understand that this procedure works on the growing hairs (anagen) and not on dormant hairs. I understand that I will require several treatments to obtain a significant, long-term reduction of hair growth. I understand I may experience fewer, thinner, lighter, slower re-growth of hairs, temporary hair loss or permanent hair reduction. I understand that it is only effective on hair with color and does not treat blonde, white or grey hair. I understand that genetics, hormones, medications, and hair color may interfere with hair loss.

The procedure may result in the following adverse experiences or risks:

- **DISCOMFORT/PAIN** – Some discomfort and/or pain may be experienced during treatment but is unlikely.
- **REDNESS/SWELLING/BRUISING** – Short term redness (erythema) or swelling (edema) of the treated area is common and may occur. There also may be some bruising.
- **HYPOPIGMENTATION / HYPERPIGMENTATION: (Changes in skin Color):** – During the healing process, there is a slight possibility that the treated area may become either lighter (hypopigmentation) or darker (hyperpigmentation) in color compared to the surrounding skin. This is usually temporary, but, on a rare occasion, it may be permanent.
- **WOUNDS** – Treatment can result in burning, blistering, or bleeding of the treated area(s), but is unlikely.
- **SUN EXPOSURE / TANNING BEDS / ARTIFICIAL TANNING** - May increase risk of side effects and adverse events.
- If any of these occur, please call our office.
- **SCARRING** – Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the chances of scarring, it is **IMPORTANT** that you follow all post-treatment instructions provided by your healthcare staff.
- **EYE EXPOSURE** – Protective eyewear (shields) will be provided to you during the treatment. Failure to wear eye shields during the entire treatment may cause severe and permanent eye damage.

I acknowledge the following points have been discussed with me:

- Potential benefits of the proposed procedure, including the possibility that the procedure may not work for me
- Alternative treatments such as electrolysis, waxing, tweezing and depilatories
- Reasonably anticipated health consequences if the procedure is not performed
- Possible complications/risks involved with the proposed procedure and subsequent healing period
- For best results, I have been informed that multiple treatments (typically 5-6 in total) performed at 4-8 week intervals are necessary to achieve results. Irregular treatment schedules and prolonged intervals between treatments may reduce the efficacy of laser hair removal.
- **After completing a package or 6 treatments to body or 8 treatments to face, touch-up pricing for the following areas will be:**

_____ Initials of Patient: **\$30* (Upper Lip and Chin) per area, per treatment**

_____ Initials of Patient: **\$50* (Axillae, Bikini, Brazilian, Neck) per area, per treatment**

_____ Initials of Patient: **\$90* (Legs, Back, large area touch-up) per area, per treatment**

* – Prices shown are current at the time of this consent. WDC reserves the right to adjust touch-up pricing in the future.

I understand that it is imperative that, prior to laser treatment, I report any topical or oral medications (prescription and non-prescription) that I am currently using or have used in the last 6 months prior to all laser treatments. Medications such as Accutane, Retin-A, Gold Therapy, Alpha-hydroxy acids may make your skin more susceptible to damage from the laser.

The treated area may feel like a razor burn or sunburn for up to 2 days after treatment. Aloe Vera gel or 1% hydrocortisone cream may be used after treatment for a few days if desired. Improper post treatment care, including excessive heat or sun exposure of the treated area, may increase the chance of scarring, pigmentation issues, and skin texture changes.

I have read and understand all information presented to me before signing this consent.

Signed: _____ Date: _____
(Patient or person legally authorized to consent for patient)

Witness: _____ Date: _____