METROPOLITAN
ANTI-AGING • BEAUTY • WELLNESS

Name _____

Date of Birth _____

LASER HAIR REMOVAL CONSENT FORM

I understand that Laser Hair Removal is a series of treatments that utilizes subtle pulses of laser energy that gently heats targeted hair follicles to eliminate future hair growth. I understand and accept that a complete elimination of all future hair growth is not a guarantee and is not a realistic expectation for everyone.

Please initial next to each item:

_____ I understand that hair reduction or removal requires multiple treatments in a timely manner to be effective. The hair density and growth cycle is crucial to the overall success of the treatments. My results and number of treatments required will vary according to ethnicity, skin type, hair color, age, medications, diet, weight, previous methods used to remove hair, degree of tanning, follow up care, and the area being treated.

_____ I understand that laser hair removal involves a series of treatments to achieve optimum results and the fee structure has been fully explained to me. The fee is for the series of treatments purchased and includes post treatment follow-up visits. There will be a charge for any additional treatments. Lifetime touchups are offered at 50% off the area treated when a package of six (6) or more session are purchased.

_____ Services purchased are non refundable unless the Metropolitan is unable to perform the treatment(s).

_____ The package of hair removal treatments must be done 6-8 weeks apart in order to ensure maximum results. In some cases additional treatments may be necessary.

_____ The lasers used by the Metropolitan has shown results that can permanently reduce hair or cause profound hair growth delay but results will vary from person to person.

_____ **I confirm that I am not pregnant at this time.**

_____ **I have not taken Accutane within the last 6 months.**

_____ **I have informed my technician if I am or have taken hormone replacement therapy.**

_____ I understand that areas that have been overly exposed to sun may result in my technician rescheduling treatments.

Although complications are infrequent following laser hair removal, I understand the following side effects or complications may occur or are theoretically possible and could happen to me:

_____ Eye injury is possible but unlikely, provided the supplied eye protection is properly used during laser treatment.

_____ Blistering, bruising, pinpoint bleeding or scarring may occur, but is uncommon. Additional treatment may be needed.

_____ Redness, inflammation, swelling and possible "crusting" of the hair follicle is normal and should resolve within a few hours to a few days. (See pre and post treatment care)

_____ Color changes such as hyperpigmentation (brown/red discoloration) or hypopigmentation (skin lightening) may occur in treated skin. This may take several months to resolve, if at all. These complications are almost always caused by sun exposure before or after treatments, therefore SUN EXPOSURE IS CONTRAINDICATED AND St. James Shaded SPF30 Sunscreen must be used.

_____ Loss of pigmented lesions such as freckles, which may give the appearance of a loss of pigment.

_____ Although infection is very unusual, bacterial, fungal and viral infections can occur.

_____ Activation of cold sores (herpes simplex virus) can occur around the mouth following treatment. This applies both to individuals with a past history of the virus and individuals with no known history of the virus in the mouth area. Should any type of skin infection occur, additional treatments or medical antibiotics may be necessary.

I have been candid in revealing any existing or new condition(s) I have. I have been asked at this time whether I have any questions about this procedure and I do not. I have been given a copy of pre and post treatment instructions and have consented to abide by the instructions. I understand the procedure and the risks. I accept the risks and request that AFT hair removal treatments be performed on me by a qualified technician. I hereby release my technician and the Metropolitan Clinic, LLC from all liabilities associated with the above indicated procedure.

Client Signature _____Date _____

Technician Initials _____ Date _____