

Intense Pulsed Light (IPL) Hair Removal Informed Consent Form



Please read the following carefully.

I authorize the office of Dr. Monica Scheel and/or a practitioner, operating under her guidance, to perform light-based hair removal. I understand that this procedure works on growing hairs and not on dormant hairs. For this reason, complete destruction of all hair follicles from any one treatment is unlikely, and I understand that I will require multiple treatments (6 recommended) to obtain a significant, long-term reduction of hair growth. I also understand some people may not experience complete hair loss even with multiple treatments and that it is only effective on hair with color. It does not treat white, blond, red, or grey hair.

I am aware of the following possible rare experiences/risks:

- Discomfort – Some mild discomfort may be experienced during treatment.
- Redness/Swelling/Bruising – Short term redness or swelling of the treated area is common for 5-10 minutes, but could be prolonged.
- Pigment Changes (skin color) – During the healing process, there is a possibility that the treated area can 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 – Rarely, treatment can result in burning or blistering of the treated areas. Since these are rare complications, please call our office if any of these occur.
- Infection – Infection is a possibility whenever the skin surface is disrupted, although proper wound care should prevent this. If signs of infection develop, such as pain, heat, or surrounding redness, please call our office.
- Scarring – Scarring is a rare occurrence, but it is a possibility if the skin surface is disrupted. To minimize the changes of scarring, it is IMPORTANT that you follow all post-treatment instructions carefully and apply sunscreen to treated exposed areas if exposed.
- Eye Exposure – Protective eyewear (shields or glasses) will be provided. It is important to keep the eyewear protection on at all times during the treatment in order to protect your eyes from injury.

I also understand that there are other options for treatment available and each of these other treatments has been fully explained to me. **Initials** _____

I consent to photographs being taken to evaluate treatment effectiveness. No photographs revealing my identity will be used publicly without my written consent. **Initials** _____

I understand that no insurance companies will reimburse for these cosmetic procedures. **Initials** _____

I understand that genetics, hormones and hair color may interfere with hair loss and that I may not respond at all. If I have hirsutism, polycystic ovarian syndrome, diabetes, excess thyroid, excessive hereditary hair growth, or hormone disorders, I may require extra treatments to decrease hair and maintenance treatments to keep hair reduction in effect. **Initials** _____

Continued on next page

Intense Pulsed Light (IPL) Hair Removal Informed Consent Form (continued)



Continued... Please initial each section to indicate that you understand each topic. Do not initial if you desire more information.

For Women Only:

Childbearing age: By my initials below I indicate that I am NOT pregnant. Furthermore, I agree to keep Dr. Scheel and staff informed should I become pregnant during the course of treatment. **Initials** _____

- Y N Are your periods regular?
- Y N Do you have problems with moderate to severe acne?
- Y N Do you have problems with weight control?
- Y N Do you have a personal history of excess hair?
- Y N Do you have issues with hormones or Polycystic Ovarian Syndrome?
- Y N Do you have Diabetes or a Thyroid disorder?
- Y N Have you had any previous hair removal and if so, how did you respond? _____

Before and after treatment instructions have been discussed with me. The procedure, as well as potential benefits and risks have been explained to my satisfaction. I have had all of my questions answered. I freely consent to the proposed treatment.

Patient Name (Print)

Patient Signature

Date

Witness Signature

Date