Spencer Wellness Centre
BIO-IDENTICAL HORMONES • PRP • AESTHETICS

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Informed Consent for Laser Hair Reduction

Patient Name_____ **Date of Birth**_____
Treatment Area(s)_____ **Number of treatments**_____

I duly authorized Spencer Wellness Centre (SWC), its providers, and/or trained associates to perform laser hair reduction using a dual wavelength system including diode/alexandrite/yag with a Triton machine developed by InMode.

I understand that clinical results may vary depending on individual factors, including but not limited to medical history, skin type, hair type, number of treatments, patient compliance with pre- and post-treatment instructions, and individual response to treatment. There have been no guarantees made by SWC or affiliates regarding my individual response or outcome.

I understand that there is a possibility of short-term effects such as pain, reddening, mild burning, temporary bruising and temporary discoloration of the skin, as well as the possibility of rare side effects such as burns, scarring and permanent discoloration or loss of pigment. I understand the use of lasers may cause permanent hair loss in the treated and surrounding areas. These effects have been fully explained to me _____ (patient's initials).

I understand that treatment with this system involves a series of treatments and the fee structure has been fully explained to me _____ (patient's initials).

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications. I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. I confirm that I have informed the staff regarding any current or past medical conditions, disorders, and medications taken.

I have read the list of pre-treatment, post-treatment, and contraindications given to me. I affirm I have met the requirements of treatment, have no contraindications listed, and will follow all pre and post instructions provided. _____(patient's initials).

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Patient Signature_____ **Date**_____