BELIFESTYLE™
LUXURY MEDSPA

PATIENT CONSENT FORM

FOR LIGHT BASED AND LASER HAIR REMOVAL

I hereby authorize Dr. Michael Cohen, Dr. Larry Lickstein, or any delegated associates to perform light based hair removal on me. I understand that this procedure works on the 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 several treatments 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 and does not treat white, grey, blond, or red hair. I understand that genetics, hormones, and hair color may interfere with hair loss and that I may not respond at all.

I am aware of the following possible experiences/risks:

- DISCOMFORT – Some discomfort may be experienced during treatment.
- 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.
- 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 – Treatment can result in burning, blistering, or bleeding of the treated areas. If any of these occur, please call our office.
- 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 410-321-8989.
- 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.
- EYE EXPOSURE – Protective eyewear (shields) will be provided. It is important to keep these shields on at all times during the treatment in order to protect your eyes from injury.

The following points have been discussed with me:

- Potential benefits of the proposed procedure
- Possible alternative procedures such as electrolysis, waxing, plucking and depilatories
- Probability of success
- Reasonably anticipated consequences if the procedure is not performed
- Most likely possible complications/risks involved with the proposed procedure and subsequent healing period
- Post-treatment instructions

For women of childbearing age: By signing below I indicate that I am not pregnant. Furthermore, I agree to keep staff informed should I become pregnant during the course of treatment.

Photographic documentation will be taken. I hereby do___do not___authorize the use of my photographs for teaching purposes.

ACKNOWLEDGMENT

BY MY SIGNATURE BELOW, I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE CONTENTS OF THIS PERMISSION FORM FOR LIGHT BASED HAIR REMOVAL TREATMENT, AND THAT THE DISCLOSURES REFERRED TO HEREIN WERE MADE TO ME.

Signature-Patient	**Print Name**	**Date**
Signature-Witness	**Print Name**	**Date**