Louisville Laser MED SPA

Client Agreement and Informed Consent

Name: _____ Date: _____

1. **Authorization.** I authorize Louisville Laser, to perform the procedures circled herein. Laser Hair Removal/Reduction, Facial Veins/Vascular, Pigmented Lesions/Brown Spots, Tattoo Removal, Wrinkle reduction. I understand the light pulsed system may reduce hair growth, may reduce the pigmentation and size of dark pigmented lesions, facial veins, and may result in an improvement of certain wrinkles. In order to accomplish these purposes, multiple treatments and sessions may be necessary.

2. **Possible consequences of treatment.**

a. **Skin color change.** I understand hyper-pigmentation (browning) and hypo-pigmentation (whitening) may occur after treatment, especially if I have a darker complexion. I understand these conditions usually resolve themselves within 3 -12 months after treatment. Permanent color change is rare, but is a risk I accept by undertaking this treatment. I understand avoiding sun exposure and self-tanning methods before and after treatment is crucial in reducing the risk of the color changes associated with hyper-pigmentation and hypo-pigmentation.

b. **Scarring.** I understand the light pulsed system may create a bruising and moderate burn or blister on my skin. Because the joules of electricity (the amount of power needed for effective treatment) must be just below the point of blistering my skin, the skin will turn red. I understand a risk of scarring is associated with this procedure.

c. **Infection.** I understand an outbreak of herpes simplex virus around the mouth may occur as a result of the treatments I am undertaking. I understand I must consult a physician before beginning treatment if I have a history of herpes simplex virus, or any indication of having such a virus.

d. **Bleeding.** I understand pinpoint bleeding, which is rare, may occur following brown spot and spider vein treatment procedures.

e. **Skin tissue pathology.** I understand the treatments I receive at Louisville Laser are not appropriate for lesions which may be cancerous. Only clearly benign pigmented lesions can be treated. Louisville Laser personnel has explained to me that energy directed at skin lesions may potentially vaporize the lesions, thereby rendering laboratory analysis of the specific tissue specimen impossible. I understand I should consult a physician before beginning treatment for such lesions.

f. **Allergic reaction.** I have no known allergies to tape, preservatives used in cosmetics or other topical preparations. Any known allergy which I have has been disclosed to Louisville Laser in writing. All prescription medications which may cause other severe reactions have been disclosed to Louisville Laser in writing.

I understand allergic reactions may require outside medical treatment.

g. **Multiple treatments.** I understand multiple treatments may be necessary to achieve the desired outcome.

h. **Eye protection.** Exposure of my eyes to intense light can harm my vision. I will wear the required eye protection at all times.

3. **To avoid these consequences:**

a. I understand exposure to the sun may be detrimental and harmful to me when combined with the treatments I am to receive. For this reason, I agree to avoid sun exposure to all areas being treated for at least two (2) weeks before and two (2) weeks after each treatment. This includes exposure to sunless tanning preparations, including lotions and sprays. I understand wearing sunscreen of SPF 25 or higher is necessary at all times during the entire series of my treatment(s).

b. I understand compliance with the aftercare guidelines is crucial for healing, prevention of scarring to my healing and to the prevention of scarring hyper-pigmentation and hypo-pigmentation. I have read and understand the Pre-Treatment and Post-Treatment instructions. I agree to follow the instructions carefully. All of my questions concerning the instructions have been answered by Louisville Laser personnel. I understand compliance with the recommended treating and post-treatment instructions is crucial for the healing, prevention of scarring, and prevention of other side effects and complications described herein. I understand I am responsible for the costs of any products necessary to treat any conditions which arise as a result of my treatment at Louisville Laser.

c. Medications. I have informed Louisville Laser of all medications I am taking prior to treatment, and to inform Louisville Laser immediately if there are any changes in my medications.

I understand I may not be treated while using Accutane, any photosensitizing medications, antibiotics, or the following anticoagulants: ☐

4. **Pregnant.** At the present time I am not pregnant. Should I become pregnant, Louisville Laser will not be able to treat specific areas of the body close to the developing fetus. Should I become pregnant, I will obtain written permission from my treating physician to continue any treatments at Louisville Laser

5. **Not a medical treatment**. I understand Louisville Laser provides only cosmetic treatment and insurance is not accepted as a form of payment. Treatments by Louisville Laser are not substitutes for complete dermatological examination or any other medical treatment.

6. **Scheduled appointments.** I understand 24 hour notice is required to cancel an appointment. If I fail to provide a 24 hour notice, one (1) treatment per area for each occurrence will be deducted. This means I will not receive the treatment. I understand if I am more than 10 minutes late to an appointment, I will be asked to reschedule.

7. **Payment.** No refunds will be given for any services. If I have not begun treatment within 60 days of purchasing services, I will receive a credit.

8. **Rescheduling appointments.** Occasionally, unforeseen mechanical problems may occur and my appointment will need to be rescheduled. Louisville Laser has agreed to make every effort to notify me prior to the appointment which must be rescheduled.

9. **Acceptance of risk and waiver of liability.** I understand my treatment may involve complications and or injury from both known and unknown causes. No warranty or promise has been made to me, regarding the results which may be obtained from any treatment I may receive. I am aware that follow-up treatments may be necessary to obtain desired results. I may require a number of treatments over several months with gradual results over time. Clinical results will vary from patient to patient. I agree to adhere to all safety precautions and regulations known to me by Louisville Laser during the course of my treatment. All of my questions regarding the procedure I am to undergo have been answered satisfactorily. I understand the procedure and accept the risks thereof.

10. I agree to resolve any disputes concerning my treatment with Louisville Laser through arbitration organized by the American Arbitration Association. Louisville Laser and I have agreed all costs of arbitration, including attorney fees, will be paid by the losing party.

ACKNOWLEDGEMENT:

Client/Guardian Signature: _____ Date: _____