Informed Consent

Informed Consent Medicam IPL Laser Hair Removal

Patient Name (please print):_____

Treatment Sites: _____

I duly authorize Jessica Murphy to perform the Medicam IPL Laser Hair Removal procedure and any other measures which in their opinion may be necessary.

I *understand that the Medicam IPL is a device used for laser hair removal and that clinical results may vary in different skin types and hair types. I understand there is a possibility of short-term effects such as reddening, blistering, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me (patient's initials)*_____

Clinical results vary depending on individual factors, including medical history, skin and hair type, patient compliance with pre/post treatment instructions, and individual response to treatment. I understand that epilation with the Medicam IPL system it a safe alternative
methods used for removing unwanted hair, such as shaving, waxing, chemical epilation and electrolysis.

I understand that treatment by the IPL laser hair removal system involves a series of treatments and the fee structure has been fully explained to me_____(client Initials)

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications and 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 am not pregnant at this time, and that I have **not** taken **Accutane** within the last 6 months. I **do not** have a pacemaker or internal defibrillator.

I consent to the taking of photographs and authorize their anonymous us for the purposes of medical audit, education and promotion. **Yes/No** Initial:_____

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: _____

Witness name: _____ Signature: _____

Date: _____

Medical History

Full Name: _____

Address:_____

Phone:_____ Phone (other):_____

Age: _____ Referred By: _____

Have you ever had the following?

- Current or history of cancer, especially malignant melanoma or recurrent non-melanoma skin cancer, or precancerous lesions such as multiple dysplastic nevi.
- Any active infection
- Diseases which may be stimulated by light at 5A5 nm to 1200 mm, such as history of recurrent Herpes Sim-plex, Systemic Lupus Erythematosus, or Porphyria.
- Use of photosensitive medication and/or herbs that may cause sensitivity to 515 - 1200 nm light exposure, such as Isotretinoin, tetracycline, or St. Joan's Wort.
- Immunosuppressive, including AIDS and HIV infection, or use of immunosuppressive medications.
- Patient history of Hormonal or endocrine disorders, such as polycystic ovary syndrome or diabetes, unless history of bleeding under control.
- History of keloid scarring.
- Very dry skin.
- Exposure to sun or artificial tanning during the 3-4 weeks prior to treatment.

Are you pregnant? YES / NO

What medications are you taking (including aspirin)?_____

_____

Daily consumption of alcohol. _____

Allergies:_____

_____

Are you taking any herbal preparations? (St. John's Wort, etc.) YES / NO

if yes, list:_____

Do you wear contact lenses? YES / NO

Skin type (when exposed to the sun **without protection** for about 1 hour)

- always burns, never tans: _____
- always burns. sometimes tans: _____
- sometimes burns, sometimes tans: _____
- always tans: _____
- Hispanic, Asian, Mediterranean, Middle Eastern: _____
- Black: _____

When were you last exposed to the sun (including tanning booth)?_____

Do you use chemical sun tanning lotions?_____

Are you planning a holiday in the sun?_____

Reason for visit? (area to be treated)_____

Prior treatment (if any) _____