GLOW MEDSPA

Informed Consent for Laser HAIR REDUCTION TREATMENT

Patient Name (Please Print Clearly): _____ Date: _____

This form is designed to provide you detailed information regarding Laser Hair Reduction (hereinafter the "Treatment"). Please read this form thoroughly and make sure all of your questions are answered before making your final decision to undergo treatment. After reading this document, please initial each section, sign and date in the appropriate areas.

x____ Treatment: Laser treatment reduces unwanted hair by exposure to laser light. I understand that this Treatment is completely voluntary and that the results may be unpredictable. Results vary from person to person and may even in vary in different areas on the same person. Multiple Treatments are necessary to achieve desired results and the number of Treatments recommended during my consultation is only an estimate. I also understand that the Treatment is in most cases effective, but there is no guarantee that the expected or anticipated results will be achieved.

x____ Hair Treatment Results and "Maintenance Treatments": I understand that complete hair removal is not likely but that with multiple treatments, significant long-term reduction can be achieved. I understand that the goal of my Treatment is a reduction in hair, not perfection. I acknowledge that a hair reduction of 70% is an excellent (but not guaranteed) outcome. I also understand that thinner, finer, "patchy", sparse and/or less dense hair may be the end result. Some hair will never go away completely and no hair reduction device offers 100% hair removal. I also understand that not being treated consistently may result in incomplete hair reduction. I understand that additional "maintenance treatments" may be needed in the future even if excellent results have been achieved and no guarantee can be made as to the final results.

x____ Alternatives to Treatment: I understand that alternatives to the Treatment do exist. Alternatives to hair reduction treatment include waxing, plucking, bleaching, chemical depilatories (Nare), shaving, trimming, threading, electrolysis or the use of other light based or laser devices. Because the Treatment is completely voluntary, an alternative option is no treatment at all.

x____ Hair Types and Areas: I understand that some types of hair (like white, grey, blonde, red, fine, "peach fuzz" and others) will not respond to treatment and some hair (very course and thick) may not respond to treatment. I also understand that in some cases, hair in some certain areas (specifically facial hair, side burns or neck hair [on both men and women]), back hair and other areas) may not resolve completely or may be more resistant to treatment. Rarely, unwanted hair growth (paradoxical hypertrichosis) can occur after the treatment. This is more common on the face and neck areas. The treatment for paradoxical hypertrichosis is continued hair reduction treatment.

x____ Ancestral Background: I understand that genetics play a role and that I may need more treatments than originally anticipated depending on my ancestral background and/or national origin. Middle Eastern, Mediterranean, Asian, Indian, South Asian and African-American patients (and others) may need more treatments than originally anticipated and may need more "touch up" or "maintenance treatments".

x____ Hormones: I understand that hormonal changes (puberty, menopause, post-pregnancy, menstrual hormones, male hormones, etc.) may make hair reduction more challenging and that I may need more treatments based upon my hormonal status and gender. I understand hormonal problems associated with the ovaries, adrenal glands, or thyroid can also cause unwanted hair growth and if my hair is not resolving as anticipated the staff may suggest that I visit a physician to have my hormones assessed to rule out a more serious medical condition. Some blood tests a physician may order include: DHEA-S, prolactin, TSH, FSH/LH, and steroid hormone binding globulin and others.

x____ Weight: I understand that some overweight individuals have higher levels of hormones (androgens) and thus, weight loss may decrease these hormone levels and reduce unwanted hair growth. I understand maintaining the proper weight will give me the best chance of having good results from treatment and not maintaining proper weight (being overweight) may cause hair to persist. Even being a few pounds overweight can make your hair more resistant to treatment and may require more treatments than expected.

x____ Anesthetic Cream: I understand that a topical anesthetic cream ("numbing cream") may be offered to me prior to the Treatment. In rare cases this numbing cream may cause life-threatening side effects including irregular heartbeat, seizures, breathing difficulties, coma or even death. Thus, if I choose to use this cream, I agree that I will not use this numbing cream for a longer period of time than recommended (30 minutes) and that I will not apply it to broken/irritated skin, mucous membranes (mouth, vagina, anus) or an open cut or wound. I agree to not use more than the amount recommended. Also for my safety, and the safety of others, I agree to keep it out of the reach of children and agree to not operate a vehicle while using the topical anesthetic. I agree to only use this numbing cream as instructed.

x____ Pre-Care and After-Care: I understand pre-care and after-care is entirely in my control and that my failure to follow the provided pre-care and after-care guidelines will increase the chance of complications and adverse side effects and decrease the effectiveness of the Treatment. I acknowledge that I have been (or will be given) detailed oral and printed care instructions along with a contact phone number if I have any questions about pre-care or after-care. I agree to follow all of the pre-care and after-care instructions provided to me.

x____ Adverse Side Effects & Risks: I understand that adverse side effects do occasionally occur and that serious complications are rare but possible. Adverse side effects may last many months, years or even be permanent. I also understand that additional medical treatment may

be necessary should I experience any adverse side effects and any cost associated with adverse side effects will not be covered by Glow Medspa. I also understand that I may miss work or social obligations due to adverse side effects that occur as the result of the Treatment. All of the following adverse side effects, risks, experiences and complications are possible, but not limited to the following

x_____ Freckle loss / Sun Spot Loss: I fully understand that laser and IPL Treatments may result in temporary and permanent loss of hair and/or freckles/sun spots in the treated area. I understand that the remaining skin may be lighter, pink, red, brown or even white in color.

x_____ Prolonged Healing / Itching / Hives / Sun Sensitivity: I fully understand that the Treatment may result in prolonged healing (redness, spider veins, tenderness, pain, etc.) in the treated area and surrounding areas. The time it takes for these side effects to subside and for the area to fully heal may be significant. I understand that after the Treatment I may experience itching/hives and be sensitive to sun-exposure.

x_____ Burns: I fully understand that occasionally the Treatment may cause burns. Most burns are usually superficial, temporary and heal relatively quickly. On rare occasion these burns may be deeper or more severe and cause permanent skin changes including, but not limited to, ulcers, erosions, skin discoloration, tissue texture changes, prolonged healing, sun sensitivity and scarring.

x_____ Skin Discoloration: I fully understand that temporary and permanent skin discoloration (undesired pigmentary alteration) including darker skin (hyperpigmentation), lighter skin (hypopigmentation), white skin (depigmentation) or erythema (pinkness/redness/spider veins) may result from the Treatment. I understand that tan skin, sun damaged skin, skin treated with artificial tanning products and patients with darker skin types have a much higher rate of complications and adverse side effects, specifically skin discoloration. Thus, I understand that there is a very real risk of skin discoloration (undesired pigmentary alteration) from the Treatment and I request to be treated knowing that my skin may temporarily or permanently change color as a result of the Treatment.

x_____ Tissue Texture Changes and Scarring: I fully understand that after the texture of my skin may temporarily or permanently change after treatment and it may not look and feel the way it did prior to the Treatment. Also, pre-existing texture changes will not improve with treatment. Scarring is also a rare possibility with the Treatment and I fully understand that smooth scars, raised scars, indented scars, white or pink scars, hypertrophic scars or keloid scars can occur with the Treatment. I understand these scars may be unsightly and permanent. Scars usually only occur if the patient picks at a treated area or "plucks" hairs. Also, pre-existing scars will not improve with treatment.

x_____ Eye Exposure: I understand that protective eyewear (goggles) will be provided to me to prevent laser exposure. I fully understand that improper use or lack of eyewear may result in vision complications including blindness and I agree to wear protective eyewear at all times during Treatment. I also understand that accidental light exposure can occur and I agree to take all possible precautions.

x_____ Sun Exposure: I agree to avoid purposeful tanning and incidental sun exposure during the course of my treatment and understand I may have to reschedule my appointment if I am tan. I also understand that tan skin is more likely to experience unwanted side effects.

x_____ I acknowledge that the Treatment has been explained to me in detail, I have thoroughly reviewed this entire form and I understand it.

x_____ I have been sufficiently informed of the possible outcomes, risks and side effects of the Treatment and topical anesthetic cream use.

x_____ I agree to follow all pre-care instructions, after-care instructions, numbing cream instructions and to keep my appointments.

x_____ I agree to allow Glow Medspa to perform emergency procedures and care in the unlikely event that unforeseen circumstances arise.

x_____ I have been given ample opportunity for discussion and have been provided satisfactory answers to every one of my questions.

x_____ I agree to start or maintain a relationship with a primary care physician (PCP) and/or OB/GYN as Glow Medspa only implements Laser Treatment and does not diagnose, treat, or cure any other medical conditions. Our staff can refer you to a physician if you do not have one.

My initials above and signature below acknowledges that the above information has been carefully read and fully understood by me and authorizes New Look Aesthetics, and its employees, independent contractors, associates, agents and representatives (collectively and hereby known as, "Glow Medspa",) to perform, implement, and/or assist in the laser treatment procedure I have elected to undergo. I agree that this Informed Consent shall be effective for the first Treatment and for any and all subsequent Treatments I receive in the future. I acknowledge that this form constitutes full disclosure but may be supplemented by other verbal and/or written disclosures provided to me.

X_____ **X**_____

PRINTED NAME OF PATIENT TODAY'S DATE

X_____ **X**_____

SIGNATURE (or signature of legal guardian if patient is under 18) (Office use only- Staff signature)