

Naficy Medical Group

27512 Calle Arroyo, Suite A, San Juan Capistrano, CA 92675 ~ (949) 489-0773

GentleLASE Hair Removal Patient Consent Form

I authorize **K. MITCHELL NAFICY, M.D., INC.** to perform Candela GentleLASE therapy on me.

The Candela GentleLASE Laser is a device that uses light energy to selectively heat and destroy the hair follicle without harming the surrounding tissue.

My eyes will be covered with laser safety eyewear or an opaque material to protect them from the intense light. My eyes will be closed and I will not attempt to remove the eye protection during treatment.

I have been informed of the following possible risks and complications of this procedure including but not limited to (Circle all that apply):

Purpura (red-purple discoloration, bruising)

Hyperpigmentation (darkening of the skin)

Hypopigmentation (lightening of the skin)

Itching (hive-like response)

Bleeding, infection, burns, blisters, textural changes, scarring, swelling, redness, discomfort

Individual sensitivities may be activated such as herpes simplex virus, hirsutism (increased hair growth) or lymphadenopathy (enlarged lymph nodes).

Redness, swelling, and discomfort are temporary and will resolve in a few hours, days, weeks, or months. Some complications, such as scarring, hyper- and hypopigmentation, may be permanent.

I understand that complete clearing may not be possible and may depend upon the type, location, and color of the hair. Multiple treatments may be needed for the best results.

Other methods of treating this condition have been discussed with me such that I may assess the risks and benefits of these alternative treatment methods.

Anesthesia is usually not necessary. My provider or I may elect to use a form of topical anesthesia to reduce any discomfort during the procedure. A cryogen spray skin cooling device may be used during the procedure to decrease discomfort and protect the skin. All anesthesia options and risks will be discussed with me in advance.

I understand that immediately following the laser treatment, redness, swelling, discomfort, may develop at the treatment site. I understand that any redness, swelling, or discomfort should resolve within several hours, but occasionally may last for 2-3 days. The treated area may feel like a sunburn (minor discomfort) for a few hours after treatment. Discomfort may be treated with the application of cool compresses or topical soothing agents.

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GentleLASE Hair Removal Patient Consent Form (Continued)

I will be given complete instructions regarding after care of the treated area. It is important to follow after care instructions carefully to minimize the chance of incomplete healing, skin textural changes, or scarring. Sun avoidance and/or use of a sunblock may be recommended. Tanning should be avoided.

I have been given the opportunity to ask questions about the procedure. My questions have been answered and I understand the information given to me.

_____ I have provided my past and current medical history and medications.

_____ I consent to the taking of photographs during the course of my laser therapy for healthcare records.

_____ I consent to using my photographs for medical education and /or marketing purposes.

_____ My name will not be used to identify these photographs.

_____ I am not pregnant (female patients).

Contraindications to the performance of this procedure have been discussed in detail with me.

I recognize that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me concerning the results of such procedures.

I have read and understood all information presented to me before signing this consent form.

Signed: _____ **Date:** _____

Witness: _____ **Time:** _____