Central Carolina Skin & Dermatology Center, P.A.

Laser Hair Removal Informed Consent

My signature below constitutes my acknowledgement that:

I _____ DOB_____ consent to and authorize Dr. Ana Benitez-Graham, M.D and members of her staff to perform multiple treatment laser-assisted hair removal and related services on me.
Areas to be treated are_____

The nature and purpose of the treatment have been explained to me and questions I have regarding the treatment have been answered to my satisfaction. A darkening or lightening of the skin may occur, at times up to many months following treatment. Also noted in some patients are superficial erosions, bruising, blistering, redness, and swelling. There is a rare possibility that a scar may develop at the treatment site. A history of psoriasis may exacerbate lesions.

Alternate means of treatment and their risks and benefits have been explained to me and I understand that I have the right to refuse treatment.

No guarantee, warranty, or assurance has been made to me as to the results that may be obtained.

I certify that I have read this entire Informed Consent and that I understand and agree to the information provided in this form. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18,1 understand that the consent of my parent/guardian having legal custody will also be required before treatment. This Informed Consent is freely and voluntarily executed and shall be binding upon my spouse, relatives, legal representatives, heirs, administrators, successors, and assigns. I agree that the pictures taken of my treatment site may be used for publication or teaching purposes, however, my name will not be disclosed and complete confidentiality will be maintained.

I agree to adhere to all safety precautions and regulations during the laser treatment.

I understand that the treatments are usually sold in packages to achieve maximum results and that a single treatment may not be sufficient to provide the desired effect.

I understand that treating skin tanned by the sun or artificial tanning products will result in possible burning and scarring, **Therefore, I must inform the laser provider of any resent sun exposure, tanning, and artificial tanning.**

Medical History Disclosure:
Central Carolina Skin & Dermatology Center wants to provide me with the utmost level of care. Thus, I am aware of the importance of disclosing my complete personal medical history. I will notify Central Carolina Skin & Dermatology Center of changes in my healthcare as they occur during my treatment process. In addition, I will also inform Central Carolina Skin & Dermatology Center of all medications that I currently take, including but not limited to : prescription and over-the-counter drugs, herbs, supplements, vitamins and birth control. I understand that any failure to do so on my part may result in an increase in the likelihood of side effects or complications post treatment.

Patient Name Printed:

Patient Signature: _____ Date:_____

Witness Signature:_____ Date: _____