

**Eastside Primary Care & Wellness**  
**1601 116<sup>th</sup> Ave NE Suite 111**  
**Bellevue, WA 98004**  
**(p) 425.467.1314**  
**(f) 425.458.3102**

**Consent Form: Hair Removal Treatment**

The Profile laser produces an intense burst of light that is absorbed by the hair follicle selectively. All personnel in the treatment room, including myself, will wear protective eyewear to prevent eye damage from this intense light.

The sensation of the light is uncomfortable and may feel like a slight pin prick or sensation of heat, which lasts may last for a few hours.

Following the procedure, the treated area may be red for a few hours or a few days. Blistering may occur. The area should be treated delicately following treatment. Multiple procedures may be necessary. I have been informed that hyperpigmentation (darkening of the skin) and hypopigmentation (lightening of the skin) are possible risks and complications of the procedure. I understand that not adhering to the post-care instructions provided to me may increase my chance of complications.

I consent to the taking of photographs during the course of my laser therapy for the purpose of medical education. These photographs may be used for teaching or publication, as the case provider deems appropriate. If I do not want, under any circumstances, my photographs to be published, I will express it in writing.

I have read and understand all information presented to me before signing this consent. I have also been given the opportunity to ask questions.

Patient \_\_\_\_\_ Date \_\_\_\_\_  
(or legal guardian)

Witness \_\_\_\_\_ Date \_\_\_\_\_

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**Profile  
Consent Form: Hair Removal Treatment**

Patient \_\_\_\_\_ Date \_\_\_\_\_

- I. The purpose of this treatment is to reduce or eliminate unwanted hair. I understand that the results from this treatment vary with each individual.
- II. The Profile laser produces an intense burst of light that is absorbed by the hair follicle selectively. All personnel in the treatment room, including myself, will wear protective eyewear to prevent damage from this intense light.
- III. The sensation of the light is uncomfortable and may feel like a pin prick or burst of heat that lasts a few hours. The use of anesthesia is at the discretion of the case provider. Nevertheless, all the options and possible side effects will be discussed with me.
- IV. Multiple treatments may be necessary. I have been informed that blistering, scarring, hypopigmentation (lightening of the skin) and hyperpigmentation (darkening of the skin) are possible risks and complications of this procedure. I understand that not adhering to post care instructions may increase my chance of complications. The area should be treated delicately following treatment.
- V. I consent to the taking of photographs during the course of my laser therapy for the purpose of medical education. These photographs may be used for teaching or publication, as the case provider deems appropriate. If I do not want my photographs to be published, I express it in writing.

I certify that I have read and understand all information presented to me before signing this consent form. I have also been given the opportunity to ask questions.

Patient \_\_\_\_\_ Date \_\_\_\_\_  
(or legal guardian)

Witness \_\_\_\_\_ Date \_\_\_\_\_

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**Profile**  
**Consent Form: Hair Removal Treatment**

The procedure to be performed is Profile laser treatment. I understand that the results from the treatment vary with each individual. The purpose of this treatment is to reduce or eliminate unwanted hair.

The Profile laser produces an intense burst of light that is absorbed by the hair follicle selectively. All personnel in the treatment room, including myself, will wear protective eyewear to prevent damage from this intense light.

The sensation of the light is uncomfortable and may feel like a pin prick or a sensation of heat that lasts only a few hours.

Multiple treatments may be necessary. The area should be treated delicate after treatment. I have been informed that possible risks and complications of this procedure may be blistering, scarring, hypopigmentation (lightening of the skin) and hyperpigmentation (darkening of the skin). I understand that not adhering to the post care instructions may increase my chance of complications.

Photographs may be taken throughout the course of the laser treatment so we may follow therapy progression. These photographs may be used for educational purposes. In the event that the patient does not want photographs to be published, patient must put it in writing that photographs may not be used under any circumstances.

This consent is a written confirmation of a discussion I have had with my case provider and/or nurse regarding the procedure aforementioned. I certify that I have read and understand all information that has been presented to me before signing this form.

Patient \_\_\_\_\_ Date \_\_\_\_\_  
(or legal guardian)

Witness \_\_\_\_\_ Date \_\_\_\_\_