

ELEVATED IMAGE

Advanced Medical Aesthetics & Primary Care • Joshua Le, DO

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INFORMED CONSENT FOR LASER HAIR REMOVAL

Laser / IPL Hair Reduction

Patient name		Date of birth	
Date of treatment		Provider	Joshua Le, DO

Treatment area(s): _____

Treatment area(s): ☐ Face ☐ Underarms ☐ Bikini/Brazilian ☐ Legs ☐ Arms ☐ Back/Chest ☐ Other: _____ Fitzpatrick skin type (I-VI): _____

1. How Laser Hair Removal Works

The laser targets the pigment (melanin) in the hair follicle, using heat to reduce future hair growth. It works best on dark hair; light, gray, blonde, or red hair responds poorly and may not respond at all. Multiple sessions are required because only hairs in the active growth phase are affected at each visit.

2. Sessions & Expected Results — "Reduction," Not Permanent Removal

- **Permanent hair REDUCTION:** The accepted result is long-term reduction in the number and thickness of hairs — NOT complete, permanent removal of all hair. Some hair usually remains or regrows.
- **Multiple sessions & maintenance:** Typically 6–8+ sessions spaced weeks apart, with occasional maintenance. Hormonal factors (e.g., PCOS) can reduce results.
- **No guarantee:** Individual results vary and cannot be guaranteed.

3. Alternatives

Alternatives include: no treatment; shaving, waxing, threading, or depilatories; electrolysis; and prescription topical creams. Each has its own results, risks, and cost.

4. Medical History & Contraindication Screening

Are you pregnant or breastfeeding?	Yes ☐ No ☐
Recent sun exposure, tanning bed, or self-tanner within the past 2–4 weeks?	Yes ☐ No ☐
Have you waxed, plucked, threaded, or had electrolysis in the area recently? (The root must be present.)	Yes ☐ No ☐
Isotretinoin (Accutane) use within the past 6–12 months?	Yes ☐ No ☐
Photosensitizing medication, or history of photosensitivity?	Yes ☐ No ☐
History of cold sores / herpes simplex (HSV) if treating the face/bikini area?	Yes ☐ No ☐
History of keloid or hypertrophic scarring, or hyperpigmentation?	Yes ☐ No ☐
Tattoos or permanent makeup in the treatment area?	Yes ☐ No ☐
Hormonal disorder (e.g., PCOS), or a light-triggered seizure disorder?	Yes ☐ No ☐
Active infection, rash, or open skin in the treatment area?	Yes ☐ No ☐

Other medications, supplements, allergies, or conditions: _____

5. Risks and Potential Side Effects

- **Discomfort, redness & swelling:** A snapping/warm sensation; redness and bumps around follicles (perifollicular edema) that usually settle within hours to days.
- **Blistering or burns:** Uncommon; more likely with recent tanning, darker skin, or aggressive settings.
- **Hyperpigmentation or hypopigmentation:** Temporary or, less commonly, prolonged color change; higher risk in darker skin (Fitzpatrick IV–VI).
- **Scarring:** Rare; risk increases with burns, infection, or picking.
- **Paradoxical hair growth (hypertrichosis):** Rarely, treatment can stimulate finer/darker hair, particularly on the face/neck in darker skin types.
- **Incomplete or temporary results:** Reduction is not permanent removal; maintenance is often needed.
- **Infection & HSV reactivation:** Uncommon; keep the area clean and take antivirals if prescribed.
- **Eye injury:** Protective eyewear is worn at all times; treatment inside the bony orbital rim is not performed.

6. Pre- & Post-Treatment Care

- SHAVE the area before treatment; do NOT wax, pluck, or thread between sessions (the follicle root must be intact).
- Avoid sun/tanning and self-tanner before and after; use broad-spectrum SPF on exposed treated skin.
- Avoid hot showers, saunas, hot tubs, and strenuous exercise for ~24-48 hours; do not pick or scratch.
- Report blistering, spreading redness, or signs of infection to the clinic promptly.

7. Photography, Financial & Acknowledgments

I consent to clinical photographs for my record and treatment planning (other use requires separate authorization). I understand this is an elective, self-pay treatment priced per session/area, that the result is hair REDUCTION (not permanent removal), and that multiple sessions and maintenance at additional cost are typically required. My screening information is true and complete. I may withdraw consent at any time.

8. Consent to Treat

I have read and understand this consent, my questions have been answered to my satisfaction, and I consent to laser hair-removal treatment(s) by Joshua H. Le, DO, and/or designated staff.

_____	_____	_____
_____	_____	_____
Patient signature	Print name	Date
_____	_____	_____
_____	_____	_____
Provider signature (Joshua Le, DO)	Witness (if used)	Date

Office Use — Treatment Record

Date	Device / wavelength	Settings / fluence	Area / spot

TEMPLATE — verify against Washington State disclosure requirements and your malpractice carrier before clinical use.



Image & Primary Care

Dr. Joshua Le, DO