AOB
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MED SPA

INTENSE PULSED LIGHT

HAIR REMOVAL, ACNE DISORDER, PHOTO-REJUVENATION, PIGMENTATION/VASCULAR DISORDER INFORMED CONSENT FORM

_____

Last Name **First Name**

This consent form is designed to verify that you have been satisfactorily informed and educated in respect to Intense Pulsed Light (IPL) treatment, as well as its aftercare, so that you may make an educated decision as to whether to have this procedure performed.

By checking the box(es) below, I am requesting IPL treatment for the following:

☐ **Hair Removal:** a non-invasive procedure using varying intensities of light in an attempt to reduce or eliminate unwanted hairs

☐ **Acne:** a non-invasive method to reduce and often eliminate unwanted acne.

☐ **Photo-Rejuvenation:** a non-invasive procedure using varying intensities of light to try to rejuvenate the skin and improve the state of photo-injured or aged skin by stimulating the formation of collagen and elastin to help soften the appearance of fine lines and wrinkles

☐ **Pigmentation:** a non-invasive method to reduce and often eliminate unwanted skin pigmentation, sun-spots, and solar freckles, often due to sun exposure or aging.

☐ **Vascular:** a non-invasive method to reduce and often eliminate unwanted vascular disorders such as broken capillaries, rosacea and cherry angiomas.

Please read and initial each paragraph below and freely ask us any questions you may have.

GENERAL INFORMATION:

_____ Prior to receiving this IPL treatment, I have been accurate and complete in completing my Client Information and Medical History form, including all of my current prescription and over the counter medications, all of the nutritional supplements I use, and all of the diseases, disorders, allergies, and medical conditions I have, including but not limited to systemic and chronic disease, skin conditions, and clotting disorders. Certain conditions may prevent me from receiving IPL Therapy, such as cancer, active infections, open lesions/skin inflammation, sun allergies, autoimmune/adrenal disorders, blood coagulation disorders, and epilepsy.

_____ _____

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_____ I understand that this is a process and therefore not an exact science and clinical results may vary based on individual factors, including medical history, skin and hair type, my compliance with pre/post treatment instructions, and individual response to treatment.

_____ I am aware of alternative methods of treatment and have made an independent decision to proceed with IPL treatments.

_____ I confirm that I am not pregnant at this time.

_____I have not taken Accutane within the last 6 months.

_____I do not have a pacemaker or internal defibrillator.

_____ I understand that a sun tan, use of tanning beds, any UVA light sources, Vitamin A creams, glycolic acid products, or tanning products may cause complications and reduce the effectiveness of IPL therapy. The areas of my body that will be treated with IPL therapy have not, during the past 14 days, been tanned by the sun, tanning booths or beds, any other UVA light, Vitamin A creams, glycolic acid products, or any tanning cream or lotion.

_____ I understand there may be some degree of discomfort such as stinging, and a feeling of warmth, which may be relieved with pre-treatment and post-treatment cooling packs and a sub-zero cooling system in the IPL device.

_____ I understand there are no guarantees as to the results of this treatment.

RISKS/SIDE EFFECTS:

_____ I understand that failure to use the eye protection provided to me during IPL therapy may result in damage to my eyes, so I will use the eye protection provided to me as recommended by the manufacturer of the IPL device, the Occupational Safety and Health Administration and the AOB Med Spa staff.

_____ I understand that this procedure may have side effects, including but not limited to pain, skin irritation and dryness, swelling and bruising of the treatment site, blistering and scarring of skin, the appearance of scabs, red skin or red spots, lightened or darkened areas of skin (hypo and hyper-pigmentation), and reactivation of Herpes simplex. Some side effects may be long lasting or even permanent.

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_____ With full knowledge and understanding of the risks/hazards discussed above, I voluntarily request the IPL procedure be performed. I have been informed of the nature, risks, and possible complications and consequences of IPL procedures. I accept full responsibility for the decision to have this procedure performed on me in light and I accept the possible consequences of said procedure.

TREATMENT AND FOLLOW UP CARE

____ I understand that multiple IPL therapy treatments may be necessary to achieve optimum results. The number of sessions will vary for each person. There is no way to predict in advance how many sessions will be needed. The technician may adjust the number interval between sessions based upon results. Hair removal is less effective if it is allowed to grow to full length between sessions.

___ I will not expose the IPL treated areas to sun, a tanning bed, any UVA light, Vitamin A creams, glycolic acid products, or any tanning cream or lotion for at least 14 days following my IPL treatment.

____ I will not use any depilatory (hair removal) cream or lotion during or after my IPL treatments. I will wait 1 month after waxing before I receive IPL hair removal treatments. I will not wax or tweeze any area of my body while I am receiving IPL therapy treatments. I understand that I can shave the treated areas of my body.

____ I will follow all treatment and skin care instructions I receive before and after my IPL therapy treatments.

_____ I understand that although complications are rare, sometimes they may occur and that attention may be necessary. In the event of any complication, I will immediately contact the center.

AUTHORIZATION AND WAIVER

_____ I hereby authorize AOB Med Spa, its employees, and agents to perform the skin care procedure on me. I fully understand that this procedure has limited applications. I am aware that the practice of non-surgical cosmetic procedures is not an exact science and I acknowledge that AOB Med Spa cannot guarantee quality and/or results or freedom from complications. I acknowledge that I have had the opportunity to ask questions, and that I fully understand the procedure.

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_____ I understand and acknowledge that there are risks involved with IPL, including but not limited to those side effects listed above. I have had the opportunity to ask questions regarding these risks and other possible complications. I understand that any false or misleading information I have given may lead to undesired results and complications and hereby release and hold harmless AOB Med Spa from any and all liability if such results or complications occur. I further understand that my failure to follow post treatment instructions may also lead to undesired results, complications or effects and hereby release and hold harmless AOB Med Spa from liability if such results or complications occur.

_____Any payment made on AOB Med Spa treatments is non-refundable. Any unused treatments will be available as an in-house credit on your account, and can be used to purchase treatments or products.

I certify that I have read and fully understand the above paragraphs, that I have had sufficient opportunity for discussion and to ask questions, and that I hereby consent to the procedure described above.

_____ _____
Client Signature (or Responsible Guardian) Date

_____ _____
Witness Date

_____ _____
Tech Initials Date