INFORMED CONSENT FOR LASER HAIR REMOVAL TREATMENT

Copeland Medical LLC
Francis Aubrey Copeland MD
Medical Director
15445 West 49th Drive
Golden, CO 80403

Patient Name _____ Date _____

Service to be Performed _____

Thank you for choosing this independently owned and operated healthcare facility. We hope you have a good experience here with us today.

The purpose of treatment is to diminish or remove unwanted hair. The treatment requires more than one procedure. Alternative options would include shaving, waxing, electrolysis, chemical epilation or no treatment.

Disclosure: The following problems may occur with the above treatments: you may experience short term itching, stinging, redness, swelling, allergic reaction, dryness, mild burning, temporary bruising or blistering, scabs, crusting, scarring, urticaria/hives, discomfort or a feeing of tingling or numbness around the area treated. Hyper-pigmentation (darkening), hypo-pigmentation (lightening) and texture changes have also been noted after treatment. These conditions usually resolve within 3-6 months, but permanent color change is a rare risk. Avoiding sun exposure before and after the treatment reduces the risk of color change. There is a slight risk of scarring. Though infection following treatment is unusual, bacterial, fungal and viral infections can occur. Herpes simplex viral infections around the mouth can occur following a treatment. This applies to both individuals with a history of herpes simplex virus infections and individuals with no known history of herpes simplex viral infections in the mouth area. If any type of skin infection occurs, additional treatments or medical antibiotics may be necessary. Pinpoint bleeding is rare but can occur following treatment procedures. Should bleeding occur, additional treatment may be necessary. In rare cases, local allergies to tape, preservatives used in cosmetics or topical preparations have been reported. Systemic reactions (which are more serious) may result from prescription medicines. There is also the possibility that other side effects or complications, not presently known, recognized, described or understood may develop now or in the future. Other rare risks and complications can occasionally be seen. These include but are not limited to: purpura (purple bruising), infection (picking at the area treated), crusting/scab on ingrown hairs, new growth of treated hair (depending on previous hair removal methods), failure to improve 'quality of life', initial unsightly appearance, interruption of daily life, work routine, home/family life or social life.

Contraindications: Do not have laser procedure if you have history of melanoma, raised or suspicious moles, lesions, keloid scars, active skin infections, hives, herpes, tattoos or permanent make-up in treatment area, recent Accutane use (6 months), tetracycline, HRT/hormone replacement therapy, St. John's Wort, autoimmune disorders, pregnant or nursing or tanned skin 2 weeks prior to therapy.

Delegation

Aubrey Copeland MD is licensed to practice medicine in the State of Colorado. He is delegating service to

Delegatee _____

Clinic _____

Telephone _____

The service the patient is receiving is a medical service; the delegatee of the service does not have a medical license in the State of Colorado. The delegatee is providing the service pursuant to the delegated authority of the physician; and, the delegating physician is available personally to consult with the patient or provide appropriate evaluation, treatment or referrals in relation to the delegated medical services.

Acknowledgement

1. I understand the potential benefits of the proposed elective procedure, and alternative treatment options
2. I understand there are no guarantees from the treatments provided, that in the practice of medicine there are some risks to treatment
3. I understand more than one procedure may be needed
4. I have disclosed a full and accurate personal medical history
5. I have read the above disclosure, and by signing below I give consent to proceed with the medical service
6. My questions regarding the procedure have been answered satisfactorily by the delegatee and I have the option to have my consultation, evaluation or treatment performed by the Medical Director, Aubrey Copeland MD
7. I understand the procedure and accept the possible complications
8. I hereby release the delegatee, clinic, and Aubrey Copeland MD from all liabilities associated with the above indicated procedure
9. I understand exposure of my eyes to laser light could harm my vision so I must keep eye protection on at all times
10. I agree to allow the medical services to be performed by a delegatee of Aubrey Copeland MD
11. I understand most insurance companies will not cover this treatment
12. I agree to comply with after-care guidelines which are crucial for skin healing, prevention of scarring and hyper-pigmentation
13. I will not expose my skin to the sun for at least 2 weeks post treatment
14. In the event of any adverse reaction I will call the healthcare facility promptly at the number above and the physician is available to meet me

Patient/Guardian Signature _____ Date _____

Delegatee Signature _____ Date _____

Copy - Patient and Patient's Medical Record