Informed Consent to Treat: Laser Treatments

I **have been informed of the risks associated with cosmetic laser services including; hyper and hypopigmentation, burning, scarring, hives, blistering, redness, swelling, itching and other similar side-effects and reactions**. I confirm that **all** of the following are accurate:

- I have **not** had UV exposure on the treatment area(s) for at least **7** days prior to my treatment and I will avoid UV exposure for **7** days after my treatment.
- I have **not** experienced a UV tan or burn for at least 2 weeks prior to my treatment.
- I have **not** applied any self-tanning products within the last **7** days.
- I did **not** experience any serious adverse reactions from my previous laser treatment.
- I have **not** started any new topical or oral medications or skin care programs since my last treatment, and if so, I have written the medications in the "Notes" section below.
- I do **not** have any new medical conditions, and if so, I have written the medical conditions in the "Notes" section below.
- I have **not** used any Retin-A (acne treatment), salicylic acid, beta/alpha hydroxy acids, benzoyl peroxide, or other similar prescription or over-the-counter products in the last **7** days.
- I am **not** pregnant or on my menstrual cycle.
- My body Temperature has **not** elevated for 2 hours prior to this treatment, and will not be for at least 2 hours.
- I agree to wear protective eye wear during each treatment. I understand that failure to do so may result in damage to my eyes.
- I certify that I have read the consent and was offered a copy. I am aware that it is my responsibility to inform the technician, esthetician, doctor, or nurse of my current health conditions or any changes since the date of my last signature. A current medical history is essential to execute appropriate treatment procedures.

If **any** of the above statements is inaccurate then I understand that Simplicity strongly recommends I reschedule my treatment. If I choose to continue with my treatment then I accept:

1. the increased likelihood of experiencing the side-effects listed above; and
2. the increased likelihood that I will not receive optimal results from this treatment; and
3. that my money will not be refunded due to side-effects or lack of desired results.

Client Signature	Date	Notes	Rest. Gel Post	SPF Post	Tech Initials