IOIO STUDIO™

Light Shear Laser Hair Removal Information and Consent

I understand that the purpose of this procedure is to reduce and/or remove unwanted hair. There are several alternatives to laser hair removal treatment including but not limited to electrolysis, shaving, waxing, plucking, or no treatment at all.

I understand that the possible risks of the procedure include pain, bruising, swelling, redness, itching, skin inflammation or irritation (dermatitis), allergic reaction, ulcers, scarring, blistering, hypopigmentation, hyperpigmentation, mottling of skin vascularity and pigmentation, and other unforeseen complications, and that these can be temporary or permanent. I understand that single procedure will most likely fail to remove all my unwanted hair in the area treated. Multiple treatments are required, although we may not be able to ever remove 100% of the hair. Individual response will vary according to skin types, hair color, degree of color/tanning, follow up care, and the body area being treated. Eye injury is possible but unlikely, providing complete eye protection is properly used throughout laser treatment sessions.

I understand the treatment may be painful, but this is typically manageable without any pain medications. Color changes, such as hyperpigmentation (brown/red discoloration) or hypopigmentation (skin lightening), may occur in treated skin and may be temporary or permanent. This may take several months to resolve, if at all. Unprotected sun exposure in the weeks following treatments is contraindicated as it may cause or worsen this condition. Blistering of the skin may occur. Temporary or permanent ulceration or scarring is uncommon but may occur.

I certify that I do not have any of the following conditions which are ***contraindications*** to laser hair removal: history of melanoma, raised moles, suspicious lesions, keloid scar formation, healing problems, active infections, open lesions, hives, herpetic lesions, cold sores, tattoos or permanent make-up in area of autoimmune diseases such as Lupus, Scleroderma, Vititigo. I certify that I am not pregnant, trying to get pregnant, or nursing. I have informed my physician of my recent sun exposure and if I have had any. I understand that, while not a contraindication to treatment, the following drugs may cause increased hair growth: birth control pills, androgens (rogaine), penicillin, cyclosporins, minoxidil, steroids, Haldol, phenytoin, thyroid medications.

I have not received any type of hair removal, except for simple shaving, in the last 6-10 weeks (depending on area treated) including plucking, tweezing, waxing, depilatories, electrolysis, or other laser hair removal, as this can decrease results, I also understand that if I have had any sun exposure in the last month or self-tanning, this may increase the chance of hypo/hyperpigmentation and I have informed my physician of this, as the treatment may need to be postponed.

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Woodmere, OH 44122

- I give permission for any pictures or videotape taken of me may be used for either teaching or publication, if considered appropriate.
- I give permission for my pictures to appear in IOIO's photo album for other potential patients to view
- I have been given the opportunity to ask questions about my condition and the treatment, alternative forms of treatment, risks of non-treatment, the procedures to be used, and the risks and hazards involved, and I have sufficient information to give this informed consent. I certify that I have completely read the above form and the form has been fully explained to me, and I understand its contents. I understand that every effort will be made to provide a positive outcome, but that there are no guarantees.
- I understand the procedure and risks (temporary and/or permanent) and accept the risks, and request that this procedure be performed on me by the doctor or other qualified staff.
- I have been given pre and post procedure instructions and I understand them. If I have any questions, concerns, or signs of problems (extended redness, swelling blistering, burns, ulcers, pain, signs of infection or other), I will immediately contact IOIO and Doctor.

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Name of Patient (print): _____ Date: _____

Signature: _____

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