Tampa Laser Hair Removal

GO SHAVELESS

Please read and initial each statement. Complete, underline, or circle individual selection accordingly.

	Initials
I authorize Dr. Mahootchi and his certified technicians to perform IPL™ on me in an effort to improve Dyschromia / Hyperpigmentation / Hair Reduction / PWS /Birthmarks / Moles or Tumor growths / Rosacea / Spider veins/ Other: _____	
I understand that there is a rare possibility of side effects or serious complications including permanent discoloration and scarring. I am aware that careful adherence to all advised instructions will help reduce this possibility.	
I understand the below list of short-term effects and agree to follow matching guidelines: • Flaking of pigmented lesions – crusts may take 5 to 10 days to disappear and it is important not to manipulate or pick which may otherwise lead to scarring • Discomfort – during the procedure, I might experience a sensation similar to rubber band snap which degree will vary per my skin condition and area sensitivity but that does not last long. A mild “sun-burn” sensation may follow for typically up to one hour and will be reduced with application of cooling and soothing creams • Reddening and swelling – severity and duration depend on the intensity of the treatment and the sensitivity of the area to be treated. These phenomena may be reduced with application of cooling and/or inflammatory creams • Bruising may rarely occur and may last up to 2 weeks	
I understand that sun exposure or tanning of any sort is not aligned with the pre and/or post-care instructions and may increase the chance for complications.	
The procedure as well as potential benefits and risks have been thoroughly explained to me and I have had all my related questions answered.	
Pre and post-care instructions have been discussed and are completely clear to me.	
I understand that results may vary with each individual and acknowledge that it is impossible to predict how I will respond to the treatment and how many sessions will be required.	
I consent to photographs being taken for the purpose of documenting my progress and response to the treatment and be kept solely in my medical record.	
I agree to review the following IPL™ / laser pre-treatment compliance checklist along with my Physician and bring accurate and updated data, as instructed.	