

Lakewood Ranch
**Hair
Removal
Center**

**Apogee Elite
Consent Form
Hair Removal Treatment**

The procedure to be performed is Apogee Elite laser treatment. I understand that the results from the treatment vary with each individual. The purpose of this treatment is to reduce or eliminate unwanted hair.

The Apogee Elite laser produces an intense burst of light that is absorbed by the hair follicle selectively. All personnel in the treatment room, including myself, will wear protective eyewear to prevent damage from this intense light.

The sensation of the light is uncomfortable and may feel like a pinprick or a sensation of heat that lasts only a few hours.

Multiple treatments may be necessary. The area should be treated delicate after treatment. I have been informed that possible risks and complications of this procedure may be blistering, scarring, hypopigmentation (lightening of the skin) and hyperpigmentation (darkening of the skin). I understand that sun exposure and not adhering to the post care instructions may increase my chance of complications.

Photographs may be taken throughout the course of the laser treatment so we may follow therapy progression. These photographs may be used for educational purposes. In the event that the patient does not want photographs to be published, patient must put it in writing that photographs may not be used under any circumstances.

This consent is a written confirmation of a discussion I have had with my case provider and/or nurse regarding the procedure aforementioned. I certify that I have read and understand all information that has been presented to me before signing this form.

Print Patient Name _____

Patient Signature _____ Date _____

Print Parent/Legal Guardian's Name _____

Parent/Legal Guardian's Signature _____ Date _____

Witness _____ Date _____