Refine MD

Consent for Laser Hair Reduction

I authorize and consent to the laser and or Broad Band Light treatment of my hair with the Sciton Profile laser.

I have been advised of the advantages and disadvantages associated with this type of treatment.

I understand that a series of treatments are necessary before any changes may be seen in my hair.

I understand that the treatment with this system varies from patient to patient and body site to body site. Treatment parameters are dependent, but not limited to, the severity of my condition and the type of pigment in my skin.

Contraindications may include pregnancy, use of mediations that increase photosensitivity, diabetes, and history of keloid scarring.

I furthermore understand that no guarantees or warranties have been made to me regarding the outcome or any improvements in my condition due to this procedure.

I understand that the most common side effects from this treatment, although rare, may be pigmentation changes in my skin and scarring as well as short-term effects such as reddening, mild burning, temporary bruising, and temporary discoloration of the skin. These side effects have all been fully explained to me.

I have been given the opportunity to ask questions and have received satisfactory answers to those questions by the treating Physician and the staff.

I understand that, regardless of payment method, there will be no refunds issued for services rendered. I agree that should I have a problem of any kind whatsoever, I shall immediately notify Refine MD.

I certify that I have read and fully understand the contents of this form and that the disclosures referred to above were made prior to my signing the form below.

I understand that photographs will be used to track patient progress. These photographs may be used for promotional purposes anonymously.

Client Signature:_____

Client Name:_____

Date Reviewed and Signed:_____