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INFORMED CONSENT FORM FOR LASER HAIR REMOVAL

This form is designed to give you the information you need to make an informed choice as to whether or not undergo laser hair removal. The purpose of this treatment is to reduce or eliminate unwanted hair. Although laser surgery is effective in most cases, no guarantee can be made that a specific patient will benefit from the treatment. I understand multiple treatments are necessary. I UNDERSTAND NO GUARANTEE IS IMPLIED OR EXPRESSED. (____) Initial.

Complications of laser surgery may include:

1. **Pain and Discomfort-** The level of pain and discomfort varies with an individual's tolerance.
2. **Scarring-** This is a risk with any surgical procedure; however, unsightly scarring is rare. If you have a history of unfavorable healing, please report it before the procedure. To minimize the risk of scarring, you must follow our postoperative instructions carefully and notify Dr Robinson's office if any problems occur.
3. **Infection-** Any invasive procedure carries a risk of infection.
4. **Skin color Change-** The treated area may heal lighter or darker than the surrounding skin. These changes are usually temporary, but on occasion can be permanent.
5. **Bruising and Redness-** These changes are usually temporary when they occur. These resolve in three to four days.
6. **Excessive swelling-** This can last for three to seven days.
7. **Eye Problems-** Eye protection must be worn during the procedure to prevent eye damage.

I understand Photos will be taken and are property of Dr Robinson. I do ___ / I do not ___ agree to allow these photos to be used for publication or teaching purposes. If I agree, I understand that my name and identity will be protected and kept confidential

I understand there are alternatives to this procedure, such as accepting my present condition, using depilatories, waxing, and electrolysis.

I certify that I have read the contents of this form. The risks and benefits of the treatment have been explained to me. My questions have been answered to my satisfaction. I hereby authorize laser hair removal. I further authorize any other procedure that, in their judgment, may be necessary or advisable should unforeseen circumstances arise during the procedure. I consent to this laser treatment today and for all subsequent treatments.

Patient Signature

Date

Parent Signature (If patient is less than 18 y.o)

Date

Witness Signature

Date