

The Vascular & Vein Laser Center, Inc.  
918-341-5311  
Dr. Kyle Hrdlicka & Dr. Lawrence Brotherton

## HAIR REDUCTION CONSENT FORM

I \_\_\_\_\_ will be undergoing the process of hair reduction. The procedure will be performed by: Dr. Kyle Hrdlicka, or his assistant at the Vascular & Vein Laser Center, Inc.

- 1) I understand that the procedure(s) will include:
  - A light coating of aloe vera gel and that ice packs may be applied to the treatment site(s) following the procedure.
  - The total duration of the treatments will depend on the area to be treated.
- 2) Photographs may be taken for my chart to allow for future comparison.
- 3) Risks or discomforts which are possible related to this treatment are as follows.
  - Pain, burning/stinging sensation, or possible blistering.
  - Infection associated with the treatment site.
  - Pigmentary(color) changes at the treatment sites including decrease in skin color (hypopigmentation) lightening and/or increase in skin color )hyperpigmentation or darkening).
  - Scar formation at the treatment area.
  - Laser induced “cold-sore-like” blistering skin eruptions known as herpetic skin eruptions at the treatment site or surrounding tissue.
  - Poor cosmetic outcome.
  - Recurrence of hair growth at the treated areas.
- 4) I understand that the treatment may be repeated several times before the desired results are achieved.
- 5) Possible benefits of this treatment are as follows:
  - Delayed re-growth of the hair in the treatment area(s).
  - Lightening of the hair in the treatment area(s).
  - Decreased density of the hair in the treatment area(s).
  - Long term permanent elimination of some hairs in the treated area(s).

I understand that I am making a decision to undergo the treatment desired in the preceding sections subject to the conditions of participation described above. My signature indicates that I have decided to receive the treatment, having read and understood the information that has been provided. I have also been given the opportunity to ask any questions and discuss any of my concerns concerning my treatment and the procedure in itself. I am also aware that there is a charge for all consecutive treatments.

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Patient

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Date

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Witness

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Date

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Physician

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Date