PRAIRIE SPA

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

Initials

- I authorize Prairie Spa to perform LightSheer® Desire™ treatments on me in an effort to improve Hair Reduction/Pseudo folliculitis Barbae/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:

-***Discomfort***- during the procedure and shortly after, I might experience an itching sensation

which degree will vary per hair density, area sensitivity and treatment head used but that does

not last long. A mild“sun-burn” sensation may follow for typically up to a one hour and will be reduced

with application of cooling and soothing creams.

-***Perifollicular erythema/ edema***-severity and duration of the rash 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.

-***Micro-crusting*** over some areas with very dense and coarse hair- may take 5 to 10 days to flake off and it

is important to not manipulate or pick which may otherwise lead to scarring.

-***Bruising*** may rarely occur and may last several days.

- **I understand that sun exposure or tanning of any sort is not aligned with the pre/and or post-care**

Instructions and may increase chance for complications

_____

- The procedure as well as potential benefits and risks have been thoroughly explained to me and I

have had all 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 used for medical education or publications with applied discretion

and not revealing my identity.

_____

- 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 laser pre-treatment compliance checklist along with my Physician

and bring accurate and updated data, to the best of my knowledge.

_____

Skin type of the area to be treated: ◯I ◯II ◯III ◯IV ◯V		
Natural or artificial sun exposure in the past 3-4 weeks pre-op or the following 3-4 post-op plan	NO	YES
Use self-tanner or tan enhancers caps within the past 3-4 weeks pre-op plan	NO	YES

Photosensitive herbal preparations (St. John's Wort, Ginkgo Biloba, etc..) or aromatherapy (essential oils)	NO	YES
Diseases which may be stimulated by light at 805 nm, such as history of Systemic Lupus Erythematosus or Porphyria	NO	YES
Pregnant or possibility of pregnancy, postpartum or nursing	NO	YES
Inflammatory skin conditions (dermatitis, active acne, etc…)	NO	YES
Presence or history of active cold sores or herpes simplex virus	NO	YES
HIV	NO	YES
Active cancer (currently on chemotherapy or radiation)	NO	YES
Previous skin cancer?	NO	YES
Medical history of keloids?	NO	YES
History livedo retcularius	NO	YES
History of erythema ab igne	NO	YES
Intake of isotretinoin within the past 6 months	NO	YES
Medical history of Koebnerizing isomorphic disease (vitiligo, psoriasis)	NO	YES
Any known allergies?	NO	YES
Any tattoo and/or dysplastic nevi on requested treatment area that should be protected?	NO	YES
Intake of aspirin or anti-coagulants?	NO	YES
Easy Bruising?	NO	YES
Hormonal or endocrine disorders (PSCOS or uncontrolled diabetes?)	NO	YES
Previous hair removal procedures on requested treatment area (other IPL/laser, wax, electrolysis, etc..)	NO	YES
List of additional current medications taken		

My signature certifies that I have duly read and understood the content of this informed consent form, and gave the accurate information as to my health condition. I hereby freely consent to LightSheer®DESIRE™ treatments.

_____

_____ Name of patient (please print) Signature of patient

Date

_____

_____Name of witness (please print) Signature of witness Date