AGE-LESS
WEIGH-LESS

Informed Consent and Patient Information for Laser Treatment

My signature below constitutes my acknowledgement that I, , am a competent, consenting adult of at lease 18 years of age (or my parent or legal guardian is giving consent on my behalf). I consent to and authorize Age-Less Weigh-Less to perform the laser procedure for:

☐ **Collagen** ☐ **Spider Veins** ☐ **Pigment** ☐ **Hair Reduction**
☐ **Vascular** ☐ **Laser Peel** ☐ **Tone** ☐ **Skin Tags**

and any other treatments which in their opinion may be necessary.

I understand the ☐ **Gemini** ☐ **Venus** is a device used for ☐ **ablative** ☐ **non-ablative** dermal remodeling, and/or wrinkle reduction and that clinical result from treatments may vary. I understand there is a possibility of short-term effects such as reddening, blistering or scabbing, temporary bruising and discoloration of the skin, as well as the possibility of rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me **BT**

Clinical results may vary depending on individual factors, including medical history, skin type, patient compliance with pre/post treatment instructions, and individual response to treatment. I understand that treatment by laser involves a series of treatments and the fee structure has been fully explained to me. I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained.

I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so. I confirm that I am not pregnant at this time, and that I have not taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator. I do not have a history of keloid scarring, have not had deep chemical or mechanical peeling within the 2 weeks preceding treatment, and do not suffer from uncontrolled diabetic complications. I am aware that there maybe temporary or permanent hair loss in areas of treatment.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion. I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this form.

_____ _____
Client Signature Date