Please read and initial each statement. Complete, underline or circle individual selection accordingly.
*Physician Performing the Procedure*_____*David West M.D.*_____

Initials

- I authorize above referenced physician perform LightSheer®INFINITY™ treatments on me in an effort to improve Hair Reduction / Pseudofolliculitis 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 one hour and will be reduced with application of cooling and soothing creams
  - Skin redness and swelling – severity and duration of the symptoms 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 anti-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 not to 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 may increase the chance for complications _____
- The treatment as well as potential benefits, risks, and alternatives have been thoroughly explained to me by my physician and I have had all my 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 taken for the purpose of documenting my progress and response to the treatment and be kept solely in my medical record _____
- I consent to photographs being used for medical education or publication without revealing my identity _____

Skin type of the area to be treated: I □ II □ III □ IV □ V □ VI □		
Natural or artificial sun exposure in the past 3-4 weeks pre-procedure or the following 3-4 weeks post-procedure plan	NO	YES
Use of self–tanners or tan enhancer 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 or 1,060 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 of livedo reticularis	NO	YES
History of erythema abigne	NO	YES
Intake of isotretinoin within the past 6 months	NO	YES
Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis)	NO	YES: .....
Any known allergy?	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 (PCOS or uncontrolled diabetes?)	NO	YES: .....
Previous hair removal procedures on requested treatment area (other IPL/laser, wax, electrolysis, etc…) Within the past 6 weeks?	NO NO	YES: what/when? ..... YES
Previous skin procedures on requested treatment area (Botox, fillers, peels, etc...)	NO	YES: what/when? .....
List of additional current medication taken		

My signature certifies that I have duly read and understand the content of this informed consent form, and that I have provided the accurate information as to my medical history and health condition. I hereby freely consent to LightSheer Infinity laser procedure and accept the risks and possible complications of such treatment.

Name of patient (please print)	Signature of patient	Date and Time
Name of witness (please print)	Signature of witness	Date
Name of physician (please print)	Signature of physician	Date