Midnight Sun Family Medicine, P.C
Aesthetics Division
Laser Hair Removal
Patient Consent

I understand that laser hair removal treatment is FDA approved for permanent reduction only and is intended for epilation of hair and that clinical results may vary with different skin types, hair color and treatment area. I understand that there is a possibility of rare side effects such as scarring and permanent discoloration as well as short-term effects such as reddening, irritated raised rash, blistering, mild burning, swelling, bruising, numbing or temporary discoloration of the skin.

_____ (Patient Initial) _____ (Dr/Tech Initial)

I understand that if I have a tattoo or permanent make-up in the area to be treated, there is a possibility of blistering and lighting of the tattoo or permanent make-up.

_____ (Patient Initial) _____ (Dr/Tech Initial)

I understand that if I've had sun exposure or used a tanning bed within a 2-day period pre or post treatment, I risk a possible pigment change or blistering.

_____ (Patient Initial) _____ (Dr/Tech Initial)

I understand that this procedure works on the growing hair follicles, not dormant hair. For this reason, complete destruction of all hair follicles from any one treatment is unlikely, and I understand that I will require multiple treatments at a regular schedule interval to obtain significant, long-term reduction of hair growth. I realize that each individual's treatment response is different; therefore, laser treatment results may vary and could range in number of treatments to achieve desired results. I also understand that it may take up to 4 weeks for the treated hair to fall out.

_____ (Patient Initial) _____ (Dr/Tech Initial)

I understand that there are other options for hair removal such as electrolysis, waxing and chemical preparations. I understand the difference between these options and laser treatment, and am choosing laser as a non-invasive treatment for my hair epilation.

_____ (Patient Initial) _____ (Dr/Tech Initial)

I understand and agree the Dr. Hornberger may choose to take photos of my treatment area for the purpose of monitoring my progress.

_____ (Patient Initial) _____ (Dr/Tech Initial)

I understand that there is a 24-hour cancellation policy, and a $75.00 minimum fee or half the treatment cost will be charged, which ever is greater, if I fail to show or do not cancel at least 24 hours prior to a scheduled appointment.

_____ (Patient Initial) _____ (Dr/Tech Initial)

I also understand that once I have started my treatment program that there are no refunds.

_____ (Patient Initial) _____ (Dr/Tech Initial)

Dr. Hornberger or a representative of Dr. Hornberger has explained the contents of this form with me and I understand the nature and purpose of the laser hair removal treatment, including its risks, possible complications, and the fact that each person's treatment response may be different. Due to the fact that each individual has between 500 and 1000 follicles per square inch, of which many could be dormant and we have no way of knowing if and when they may start growing, I have read and understand this consent form and I agree to its terms and authorize treatment. I further understand that Dr. Hornberger cannot guarantee the results and I will not hold Dr. Hornberger or her employees responsible for my individual results of the hair removal treatment that I have requested.

_____ (Patient Initial) _____ (Dr/Tech Initial)

_____	_____	_____
Signature Patient or Guardian	PRINT Name/Relationship	Date
_____	_____	_____
Signature-Witness MSFM	Print Name	Date