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

Head Area: (Does not apply, Patient Initial. _____)

I fully understand that the Laser is intended for the epilation of hair removal. I have been informed that the hair on my head or scalp that I want treated will be permanently reduced. Therefore, the future ability to re-grow my hair on my head will be substantially or permanently reduced.

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

Genital Area: (Does not apply, Patient Initial. _____)

I fully understand that the Laser is intended for the epilation of hair removal. I have been informed that there is a possible risk and unknown side effects such as possible sterilization by undergoing treatment of genitals or genital area. I understand the information and the effects have been fully explained to me. I acknowledge and except full responsibility for my treatment and any possible side effects that may have been caused by the laser treatments.

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