I authorize a laser technician to perform LightSheer Duet treatments on me in an effort to improve Hair Reduction/Pseudofolliculitis Barbae. I understand that these results are not permanent but will achieve a significant reduction.

I understand that there is a rare possibility of side effects or serious complications including but not limited to permanent discoloration, burns, scarring, temporary hypo or hyperpigmentation. I am aware that careful adherence to all advised instructions will help reduce possibility.

I understand that 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 with vary per hair density, area sensitivity and treatment head used that does not last. A mild "sunburn" sensation may follow for typically up to 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.

**Micro-crusting** over some areas with very dense and course hair - may take 5-10 days to flake off and it is important not to manipulate or pick which may otherwise lead to scarring

Brusing may rarely occur and may last several days

I must disclose any new changes in medication and/or changes in my medical history every time I receive a treatment

I understand sun exposure or tanning of any sort is a risk for laser hair removal and may increase the chance of short term and/or long term complications

The procedure as well as potential benefits and risks have been thoroughly explained to me and I have had all of my 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 to keep my results

I consent to photographs being taken for the purpose of documenting my progress and will be kept in my private medical record
All statements above are true and accurate to the best of my knowledge. I hereby freely accept to be treated for laser hair removal and my signature certifies that I have read and understood the content of this consent form.

X

Patient Signature and Date