MOTYKIE medspa
By Board Certified Plastic Surgeon, DR. GARY MOTYKIE

LASER HAIR REMOVAL
CONSENT

Name of Patient: _____D.O.S_____

In signing this document, I give permission to the clinic staff of **Motykie Med Spa** to perform laser hair removal.

I understand that the goal of this procedure is the gradual permanent reduction of my hair. I understand that every individual is unique, and it is very difficult to guarantee a specific number of treatments needed. It is expected that I will require 6 to 8 treatments for the body and 4 to 6 treatments for the face, give or take one treatment.

I agree to call the clinic if I have any difficulty after my treatment. The number to call is **310-276-6772.**

I acknowledge that I have not waxed the treated area within the previous 4-6 weeks nor have I plucked the hair from the area being treated**. I acknowledge that I have not been sun tanning for the previous 4 weeks.**

Although uncommon, I understand that complications can occur. It has been explained to me that these complications include: a sunburn feeling, redness, local tenderness and mild swelling, occasionally blistering, very rarely pigmentation changes and scarring.

I understand that how I take care of my skin after treatment influences my risk of complications. I agree to wash my skin gently twice-daily and apply an antibacterial cream if irritated**. I agree to stay out of the sun or to use sufficient sun block for 4 weeks following my treatment**. I agree to call the clinic if I develop any markings on my skin after treatment, and I will not pick at them.

I have not taken Accutane within the last 12 months.

I am not currently pregnant.

I am a not allergic to any topical anesthetic (topical freezing).

Dr. Gary Motykie may show my photos to others for educational purposes. NO YES

I do understand that before and after photos must be taken to monitor treatment progress. I certify and agree that this constitutes full disclosure. I have read and fully understand the above information and that I had sufficient opportunity for discussion and/or to ask any questions. I accept the risks and complications of the procedure.
I have received the Pre and Post instructions for Laser Hair Removal.

Patient's Signature: _____Date:_____

Witness's Signature: _____Date:_____