

**Westside Aesthetics  
Informed Consent Soprano XL<sup>™</sup> Laser Hair Removal**

Patient name \_\_\_\_\_

Treatment sites \_\_\_\_\_

I duly authorize \_\_\_\_\_ to perform the Soprano Laser Hair Removal procedure and any other measures which in their opinion may be necessary.

I understand that the Soprano is a device used for laser hair removal and that clinical results may vary in different skin types and hair types. I understand there is a possibility of short-term effects such as reddening, blistering, scabbing, temporary bruising and temporary discoloration of the skin, as well as rare side effects such as scarring and permanent discoloration. These effects have been fully explained to me \_\_\_\_\_ (patient's initials)

Clinical results may vary depending on individual factors, including medical history, skin and hair type, patient compliance with pre/post treatment instructions, and individual response to treatment. I understand that epilation with the Soprano system is a safe alternative to methods used for removing unwanted hair, such as shaving, waxing, chemical epilation and electrolysis.

I understand that treatment by the Soprano laser hair removal system involves a series of treatments and the fee structure has been fully explained to me \_\_\_\_\_ (patient's initials)

I have avoided sun exposure, sun tanning booths, and tanning creams for at least (4) weeks prior and after Soprano laser hair removal system as this will increase side effects. \_\_\_\_\_ (patient's initials)

I certify that I have been fully informed of the nature and purpose of the procedure, expected outcomes and possible complications, and I understand that no guarantee can be given as to the final result obtained. I am fully aware that my condition is of cosmetic concern and that the decision to proceed is based solely on my expressed desire to do so.

I confirm that I am not pregnant at this time, and that I have not taken Accutane within the last 6 months. I do not have a pacemaker or internal defibrillator.

I consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this consent form.

Print Name \_\_\_\_\_

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness Name \_\_\_\_\_

Witness Signature \_\_\_\_\_

Date \_\_\_\_\_