**Cynosure Elite Plus Laser Hair Removal**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment Sites: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the Cynosure Elite Plus 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 the epilation with the Cynosure Elite Plus system is a safe alternative to methods used for removing unwanted hair such as shaving, waxing, chemical epilation and electrolysis. \_\_\_\_\_ (patient initials)

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

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. \_\_\_\_\_\_\_ (patient’s initials)

I consent to the taking of photographs and authorize the anonymous use for the purposes of medical audit, education, and promotion. \_\_\_\_\_\_\_ (patient’s initials)

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. \_\_\_\_\_\_ (patient’s initials)

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

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_