Dr. Steven Costalas
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Consent to Laser Hair Removal
In signing this document, I give permission to the clinic staff of KP Aesthetics 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 per client/ per area. It is expected that I will require anywhere from 8-10 treatments give or take.** _____ Initial**

Although uncommon, I understand that complications can occur. It has been explained to me that these complications include but are not limited to sunburn feeling, redness, local tenderness, blistering, and very rarely pigment changes and scarring. I agree to call KP Aesthetics if I have problems after my treatment. _____ Initial

I acknowledge that I have not waxed the treated area within the previous four weeks nor have I plucked the hair from the area being treated. _____ Initial

I agree to stay out of the sun or to use significant sun block for FOUR weeks following and prior to my treatment. _____ Initial

I have not taken Accutane within the last 12 months. _____ Initial

I am not currently pregnant or breast feeding. _____ Initial

I have not taken an antibiotic in the last 2 weeks. _____ Initial

I have not used any RetinA products in the last 6 months. _____ Initial

I will inform KP Aesthetics if I become pregnant or begin to use hormone therapy. _____ Initial

Patient Signature:_____ Date:_____

Provider Signature:_____ Date:_____