



10215 SW Hall Blvd. | Suite 200  
Tigard, Oregon 97223

CONSENT TO GentleLASE TREATMENT

I authorize Barbara Mosar under the instruction and supervision of Jan Maybee, NP to perform Candela GentleLASE therapy on the proposed/discussed areas for the purpose of long-lasting hair reduction.

The Candela GentleLASE is a devise that produces an intense but gentle burst of light that fragments and removes the target lesion (the hair follicle growth cells) by selective destruction, without harming the surrounding tissue. Because this laser uses a cooling device that delivers a spray to the surface of the skin to reduce discomfort when the laser pulse is delivered, additional anesthesia is usually not necessary. When additional anesthesia is needed/desired, options will be discussed.

I understand the following:

- Laser protective glasses or goggles are worn during laser, used by all persons in the laser room to protect eyes from damage from the laser
- Scarring, hypopigmentation or hyperpigmentation are possible risks and complications of this procedure
- Some patients with darker skin tones may be asked to prepare the treatment area one week before therapy with daily use of 4% hydroquinone cream to decrease the chance of transient hyperpigmentation
- Immediately following the laser treatment, an area of red discoloration and swelling may appear and last an hour or longer. antibiotic ointment, mild cortisone lotion, or aloe vera gel may be applied immediately after treatment
- Improper care of the treatment area may increase the chance of discoloration, scarring of the skin, or textural changes
- Multiple treatments of an area will be necessary for the best results

I consent to photographs being taken to evaluate treatment effectiveness, for medical education training, professional publications, or sales purposes. No photographs revealing my identity will be used without consent. If my identity is not revealed, these photographs may be used and displayed publicly without my permission.

I have read the above information and understand it. My questions have been answered satisfactorily and I accept the parameters of the procedure before signing this form.

PATIENT SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PRINT NAME \_\_\_\_\_

PARENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_  
(If patient is a minor)

WITNESS \_\_\_\_\_ DATE \_\_\_\_\_

BARBARA MOSAR, Medical Esthetician