



Hair removal

DIOLAZE Laser Hair Removal Consent Form

This form is designed to give you the information you require to make an informed choice of whether or not to undergo treatment with DIOLAZE technology.

- I hereby authorize Sei Tu Bella Aesthetics and/or associates to perform the DIOLAZE procedure.

- The provider obtained my medical history and found me eligible for treatment.

- I have received the following information about the technology:

DIOLAZE is a non-invasive technology that utilizes diode laser for hair removal. DIOLAZE has the highest speed and the best skin cooling system. It can be used for hairs of dark blond to black color.

No complete clearance is guaranteed.

Treatment requires 3-6 sessions based on individual assessment, area treated and treatment response.

There may be some discomfort and transient redness and/or swelling associated with treatment.

There is a small risk of adverse reactions.

- I understand that taking the treatment course is my choice and that I am free to withdraw at any time, without giving any reason.

- I was told about the possible side effects of the treatment including local pain, skin redness (erythema), swelling (edema), damage to the natural skin texture (crust, blister, burn), change of pigmentation (hyper- or hypo-pigmentation), and scarring. Although these effects are rare and expected to be temporary, any adverse reaction should be reported immediately.

- I understand that I must comply with treatment schedule, otherwise results may be compromised.

- I recognize that during the procedure unforeseen conditions may necessitate different procedures than this above and I authorize the physician or associates to perform such other procedures if they find them professionally recommended or necessary.

- I understand that not everyone is a candidate for this treatment and results may vary, therefore, there is no guarantee as to the results that may be obtained.

- Any questions I may have asked have been answered to my satisfaction.
- DIOLAZE Laser Hair Removal Patient Instructions copy has been provided to me and I understand recommended Pre-procedure and Post-Procedure Care.
- I have been provided a copy of Notice of Privacy Practices at Sei Tu Bella Aesthetics

I understand that the treatment may involve risks of complication or injury from both known and unknown causes, and I freely assume those risks. Prior to receiving treatment, I have been candid in revealing any condition that may have a bearing on this procedure.

I consent and authorize Sei Tu Bella Aesthetics , LLC, and it's affiliates to perform the procedure listed on me. I certify that I have read this entire informed consent and I understand and agree to the information provided in the form. My questions regarding the procedure have been answered satisfactorily. I hereby release Heather Anderson, APRN, Medical Director Dr. Fernando Jara, Sei Tu Bella Aesthetics LLC from all liabilities associated with this procedure. This consent is valid for all of my treatments in the future as well.