

ABSolute Weight Loss and Nutrition Center, LLC
529 North 1200 West
Orem, Utah 84057
(801) 226-5100

**CONSENT, WAIVER, AND RELEASE FORM
FOR SCITON LASER HAIR REMOVAL**

PLEASE READ THIS DOCUMENT IN ITS ENTIRETY,
AS IT AFFECTS YOUR LEGAL RIGHTS AND REMEDIES.

In the ongoing efforts of ABSolute Weight Loss and Nutrition Center, LLC (“Absolute”) to provide you with the best possible service, we ask that you carefully review this Consent, Waiver, and Release Form (“Form”) and that you ask any questions necessary to help you fully understand it. This Form shall serve as a permanent addendum to each and every procedural consent form signed by you for services rendered by Absolute. Please sign only after careful consideration.

Mechanism: The Sciton Clear Scan 1064 Laser produces a focused beam of highly concentrated light. This beam generates a wavelength of energy that is selectively absorbed by the melanin (pigment) in the hair follicle. This absorption produces heat, which in turn diminishes the follicles’ ability to grow hair. Hair growth may be eliminated and any regrowth is usually finer and lighter, making it more cosmetically acceptable. Multiple follicles are affected with each pulse of the laser. The length (time) and energy (power) of the laser pulse are adjusted to maximize results while minimizing side effects.

Safety: All recommended and required laser safety precautions and all Sciton-specific guidelines will be followed to ensure the utmost safety during your treatments. This includes the use of protective eyewear at all times while the laser is in use. Your care will be provided by a qualified laser operator who is certified by ABSolute. All operators are trained in laser science, use of the laser, laser safety, skin care, and other related areas. Required oversight by Tricia Chavez APRN is adhered to and is available to address any concerns that you may have.

Limitations: I understand that some permanent hair reduction is achieved in nearly everyone, but that complete hair removal may not occur. My results are limited by the laser capability as well as by my personal skin and hair characteristics. Fitzpatrick skin typing will be done, and I understand that a higher Fitzpatrick typing increases the risk and complications of hypo-pigmentation, hyper-pigmentation, blistering, and scarring. Hormonal therapy and other medical conditions may also affect results. These issues were discussed at the time my medical history was reviewed. Any hair regrowth is usually finer (less coarse) and lighter (less pigmented) than the original hair. A series of treatments is necessary to achieve maximum benefit. Actual results cannot be guaranteed.

Cautions: If I have a history of keloid formation, excessive scarring or poor healing (diabetes or other conditions), I will consult my personal physician prior to proceeding. I

Initial here: _____

understand that excessive hair growth may be caused by various medical conditions that may require other forms of treatment and that it is my responsibility to explore such needs prior to laser treatments. Sun tanning or self-tanning creams must be avoided for 4 to 6 weeks prior to and after laser treatments, as this may reduce the effectiveness of treatments and may increase side effects. Depilatory (hair removal) creams, plucking, waxing, or electrolysis should be avoided for 6 weeks prior to laser treatments. Discontinue use of Accutane (or products containing isotretinoin) at least 6 months prior to laser treatments. You must also discontinue the use of Retin-A (or products containing tretinoin) at least 2 weeks prior to laser treatments. Treatments cannot be performed on skin areas with open sores or lesions. Tattoos and permanent makeup in the treatment area may also be altered. Recurrent viral infections, such as herpes simplex (cold sores) or varicella (shingles), may be activated. An accurate personal medical history is to be completed and reviewed with any concerns addressed prior to treatment.

Discomfort: The physical sensation generated by the laser pulse is most commonly described as a rubber band snapping against the skin. Most individuals are able to tolerate this for the short duration of the laser treatment. You may have a sunburn-type sensation in the treatment area for several hours afterwards.

Pre- and Post-Treatment Instructions: I acknowledge receipt of pre-treatment and post-treatment instructions. I understand that failure to carefully follow these instructions may affect my treatment outcome and may increase the likelihood or severity of complications.

Skin Effects: You may experience temporary redness similar to sunburn. Some skin swelling (edema) may occur. Blistering, scabbing, infection, and other skin changes are much less likely. All of these side effects should completely resolve themselves within a few hours to several days following treatment. Scarring is extremely rare and usually occurs in those with a predisposition, such as a history of keloids, hypertrophics, or other excessive scarring. We do not advise laser treatments if you have such a history and under these circumstances cannot be responsible for the outcome. Hypo-pigmentation (decreased skin coloration) or hyper-pigmentation (increased skin coloration) is uncommon and, although rarely permanent, may last several weeks to months. Post treatment use of sunscreen is advised to minimize this risk. Please carefully follow the pre- and post-treatment instructions to reduce the likelihood or severity of any skin changes. Please carefully follow the pre- and post-treatment instructions to reduce the likelihood or severity of any skin changes.

Long Term Risk: I understand that the risks of laser use may not be fully known. The information presented to me is based on recent studies conducted over a relatively short period. ABSolute will not be held responsible for any laser risk not yet discovered or commonly known.

RELEASE, WAIVER, & REMEDIES **PLEASE READ CAREFULLY**

Release and waiver: By signing below, you understand that you (on your own behalf and, if applicable, on behalf of the minor for whom you are signing) hereby permanently and irrevocably waive any and all claims and/or causes of action, in law or equity, against Absolute, and also permanently and irrevocably release Absolute from and any liability associated with the

Initial here: _____

treatment covered by this Form, including but not limited to personal injury, pain and suffering, minor or severe physical discomfort, short- or long-term side effects, temporary or permanent alteration of physical appearance regardless of severity, etc.

BINDING ARBITRATION; NO JURY TRIAL. VERY IMPORTANT—PLEASE READ! I agree to arbitrate any and all disputes, claims, and/or controversies in law or equity between me and Absolute arising out of, related to, or in any way connected with this Form or Absolute’s services to me. Arbitration fees, if any, shall be divided equally between me and Absolute.

If I commence a court action based on a dispute or claim without first attempting to resolve the matter through arbitration, I agree to stay the court action in favor of arbitration, and I will not be entitled to recover attorneys’ fees or costs even if such costs and fees would otherwise be available to me in arbitration or a court action. I agree that the arbitration shall be conducted in accordance with the rules of the American Arbitration Association. Judgment upon the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. The parties shall have the right to discovery as permitted by the Utah Rules of Civil Procedure.

By agreeing to arbitration, and by initialing below, the patient expressly agrees that he or she is agreeing to have any dispute arising out of the matters included in this “Binding Arbitration” provision decided by neutral arbitration as provided by Utah law, and the patient is giving up any rights he or she might possess to have the dispute litigated in a court or before a jury.

I HAVE READ AND UNDERSTAND THE FOREGOING AND AGREE TO SUBMIT DISPUTES ARISING OUT OF THE MATTERS INCLUDED IN THIS “BINDING ARBITRATION” PROVISION TO NEUTRAL ARBITRATION, AND THAT BY SO DOING, I AM WAIVING MY RIGHT TO HAVE THIS DISPUTE LITIGATED IN COURT OR BEFORE A JURY.

Patient’s initials

My signature attests to the fact that I have fully read this entire Form, that I have had any concerns answered to my satisfaction, and that I understand and agree to the information contained within. I hereby consent to the use of the Sciton Clear Scan 1064 Laser in hopes of attaining the desired beneficial results. I certify that I am a competent adult of at least 18 years of age and am either receiving the treatment described herein or am signing this Form as the parent/legal guardian of a minor who shall receive the treatment described herein. This Form shall apply to all subsequent treatments of a similar nature.

Please come with the area to be treated shaved. There is a \$20 fee for areas that need to be shaved at your appointment.

Initial here: _____

Patient's signature
(signature of patient's parent/legal guardian if patient is under 18):

Printed name: _____

Date: _____

Initial here: _____