KERALASE TREATMENT CONSENT FORM

This form is designed to provide you with the information you need to make an informed decision on whether or not to have a KeraLase Treatment procedure performed. If you have any questions or do not understand any part of this consent, please do not hesitate to ask us.

I hereby authorize **[INSERT FACILITY NAME]** to perform Keralase treatment on me. I understand that the procedure is purely elective and I have chosen to receive treatment.

I understand the nature of my condition, the nature of the procedure, the alternative treatments available, and the benefits to be expected compared with alternative approaches. I understand that optimal results are achieved only with a series of treatments and that I will not see optimal results after one treatment. The need to complete a treatment plan has been fully explained to me.

- The KeraLase treatment involves the use of the LaseMD / Ultra laser and then a topical application of the KeraFactor Serum to the scalp. This helps to revitalize and rejuvenate the scalp.
- The KeraLase treatment takes around 10 minutes to complete by one of our qualified staff members. It is an easy and tolerable procedure.
- Before the treatment, the hair must be clean and free of hair products on the day of treatment. You must remain out of the sun or use sun protection (SPF or hat) for a week before and after each treatment.
- During the treatment you may feel warmth or a light sting during the laser portion of the treatment. Then product will be massaged throughout the scalp.
- After the treatment you may notice hairs in the telogen phase (resting phase) may be shed by any slight trauma due to the laser treatment and/or overly manipulating the hair and scalp (e.g. brushing too vigorously).
- Do not clean the hair for 24 hours to allow the product to fully penetrate. At home, use the recommended product solution twice daily, starting the following day after cleansing. You should expect to see rejuvenation after the series of 6 treatments is completed and up to one year. We recommend a touch up once yearly.

I consent to photographs being taken to evaluate treatment effectiveness, for medical education and training. No photographs revealing my identity will be used without my written consent.

"Before and After Instructions" have been discussed with me. The procedure, as well as potential benefits and risks, have all been explained to my satisfaction. I have had all my questions answered. I freely consent to the proposed treatment. I certify that I am a competent adult of at least 18 years of age, or that if I am a minor under the age of 18, I understand that the consent of my parent/legal guardian/person having legal custody will also be required before treatment.

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Patient Signature	Print Patient Name	Date
____________________	____________________	__________
Physician Signature	Print Phycisian Name	Date