Pacific Clinic

FOLIX LASER HAIR RESTORATION CONSENT FORM

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1. Introduction

Folix Laser Hair Restoration involves the use of low-level laser therapy (LLLT) to stimulate hair follicles and promote hair growth. It is a non-invasive treatment aimed at improving hair thickness and density. This consent form outlines the potential risks, benefits, and responsibilities associated with the treatment.

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2. Purpose and Expected Outcome

I understand that Folix Laser Hair Restoration is designed to:

- Stimulate hair growth by increasing blood flow to hair follicles.
- Encourage the production of natural hair growth factors.
- Improve the health and quality of existing hair.

Expected results may vary, and outcomes cannot be guaranteed. Some patients may not respond to the treatment as effectively as others.

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3. Procedure

The procedure involves the use of a handheld laser device that emits low-level light directly onto the scalp or affected area. Each session typically lasts between **20-30 minutes**.

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4. Risks and Side Effects

While Folix Laser Hair Restoration is generally considered safe, there are potential risks and side effects, including but not limited to:

- Temporary scalp irritation or redness.
- Mild discomfort during treatment.
- No visible results or limited results.
- Scalp sensitivity or tingling sensation.
- Temporary hair shedding/breakage

I understand the below list of short-term effects and skin responses and agree to follow matching guidelines:

- Discomfort – during the procedure, I might experience stinging or burning sensation that may last for up to several hours following the treatment.
- A mild “sun-burn” sensation may follow for typically up to one hour and will be reduced with application of air-based cooling.
- Reddening and swelling – severity and duration depend on the intensity of the treatment and sensitivity of the area to be treated. These phenomena may be reduced within a couple of hours following treatment.
- Xerosis and pruritus – within the first few days after treatment, my skin may feel itchy, tight and dry. Regular application of moisturizers helps reducing this sensation.
- “Bronzed” appearance – within the first few days after treatment, I may develop a pinkish and/or colored tone and discrete dry flaking. It is important I do not rub nor pick my skin which may otherwise lead to scarring. A broad spectrum (UVA/UVB) sunscreen SPF 30 or greater should be applied to the area(s) to be treated whenever exposed to the sun.

If any of these side effects persist or worsen, I will contact my provider immediately.

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5. Contraindications

I confirm that I do not have any of the following conditions that may interfere with the treatment:

- Pregnancy or breastfeeding.
- Active skin conditions, including open sores or infections in the treated area.
- History of cancer, unless cleared by a physician.

- Sensitivity to light or history of photosensitivity.
- Recent exposure to sun in the 4-6 weeks pre-op plan, remaining suntan or artificially toned skin
- Intake of oral Isotretinoin within the past 6 months
- Concurrent inflammatory skin conditions (dermatitis, active acne, rosacea, etc)
- Presence or history of active cold sores or HSV in the treatment area
- Immune-compromised conditions
- History of PIH (Post-Inflammatory Hyperpigmentation)
- Medical history of keloids in the treatment area
- Medical history of Koebnerizing isomorphic diseases (vitiligo, psoriasis, etc)
- Multiple dysplastic nevi in area to be treated
- Active Cancer (currently on chemotherapy or radiation)
- Previous Skin Cancer in the area of treatment
- Any tattoo/pigmented lesion on requested treatment area
- Previous skin procedures on requested treatment area (Botox, Fillers, Chemical peels, etc)

If I am unsure, I will consult with my healthcare provider before proceeding.

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6. Aftercare and Maintenance

Post-treatment instructions will be provided, and it is essential to follow them carefully to maximize the treatment's effectiveness. I understand that multiple treatments may be required for optimal results and that periodic follow-up treatments may be necessary for maintenance.

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7. Photography and Documentation

I consent to photographs being taken before, during, and after the procedure for the purpose of documenting my progress and treatment results. These photographs will be kept confidential and may be used for educational purposes.

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8. Payment and Refunds

I understand that the Pacific Clinic will require payment upfront for the treatment. I also understand that treatments are non-refundable unless specified by the clinic's refund policy. Additional sessions may incur extra costs.

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9. Consent to Treatment

By signing this consent form, I acknowledge that:

- I have provided accurate medical information to the best of my knowledge.
- I have had the opportunity to ask questions about the procedure, its risks, and expected outcomes.
- I understand that there are no guarantees regarding the success of the treatment.
- I consent to receiving Folix Laser Hair Restoration treatment.

Patient Name: _____

Patient Signature: _____

Today's Date: _____