VIRGINIA
EAR NOSE & THROAT
The Choice is Clear

Informed Consent

BBL Forever Bare – Laser Hair Reduction

I, _____, Authorize_____,

and/or a designated practitioner of _Dr. Alan Burke – Virginia ENT_ to perform _BBL Hair Reduction_

on the following area(s) of my body: _____.

BBL (BroadBand Light) Forever Bare targets hair follicles to selectively destroy them while leaving the surrounding skin intact. The purpose of this procedure is to diminish or remove unwanted hair. Hair reduction requires more than one treatment and does not remove ALL hair. Generally, it is decreased in the amount of hair growth by 60-90% on average. Results depend on color and location of hair follicles. A general range of **4-12 treatments spaced 4-8 weeks** apart is possible for maximum results.

Common Side Effects & Risk

I understand there is a possibility of rare side effects such as scarring and permanent discoloration. Hyperpigmentation (browning) and hypopigmentation (lightening) usually resolve within 2-6 months. Safe precautions with sun exposure are recommended. In addition, possible short-term effects include redness, mild burning, edema (swelling), blistering and infection. Although rare, herpes simplex virus infections around the mouth can occur, with or without a known history of cold sores. Should any kind of infection occur, please contact your clinician immediately to prescribe appropriate medicine.

Photography

I do ____ or do NOT ____ consent to photographs and other audio-visual and graphic materials before, during, and after the course of my therapy be used for medical, marketing, and educational purposes. Although the photographs or accompanying materials will not contain my name or any other identifying information, I am aware I may or may not be identified by the photos.

☐ **I understand this involves payment, and the fee structures have been explained.**

☐ **I understand there are other options for treatment that are available, which have been explained.**

I have read and understood all information presented to me before signing this consent form. The staff gave me the opportunity to answer my questions to my satisfaction. I understand the procedure and accept the risks. I agree to the terms of this agreement.

Patient's Signature: _____ **Date** _____

Witness Signature: _____ **Date**: _____

DR. ALAN BURKE
Facial Plastic &
Reconstructive Surgery