



Light Touch Hair Restoration Therapy

Consent Form

I do request and consent to the **Blue Laser Light Acne Therapy program**. I am willing to commit to a program of treatments, in the hope that I might also benefit from this new technology.

The effect and nature of this procedure to be performed has been fully explained to me. I acknowledge that no guarantee has been made to me by anyone regarding the results of the Acne Therapy treatments, which I have requested and authorized. I further understand that the procedure is safe and that I accept full responsibility for any complications which may arise as a result of this requested treatment. Acne has no known cures, and I understand that I may need additional treatments in the future. I also understand that all fees are nonrefundable.

Name: _____

Date of Birth: _____

Total Fee: \$_____ Payment Method: _____

I hereby agree to commit to the Blue Laser Light Acne Therapy Program.

Date

Patient/Parent (if minor) Signature

Date

Light Touch Representative