Informed Consent

I request and authorize Dr. ______________________ or designated person to perform the following procedure utilizing temperature controlled radio frequency technology.

This procedure is being used to treat my condition/medical diagnosis of:

____

Areas to be treated: ____.

Please initial each item:

_____The areas for treatment have been reviewed with me today and I am in agreement. I have been thoroughly and completely advised regarding the objectives of the procedure. I understand that the practice of medicine and surgery is not an exact science and although these procedures are effective in most cases, no results have been guaranteed. I acknowledge that imperfections might ensue and that the operative result may not live up to my expectations. I understand that clinical results may not be fully apparent for 6-12 months after this procedure; individual results may vary and may be age-dependent.

_____ The treatment will involve applying heat to the subcutaneous tissue and dermis using radiofrequency for therapeutic purposes.

_____ I am aware of the following possible experiences and/or risks associated with the procedure:

- I consent to the administration of local infiltration anesthesia. I understand that all forms of anesthesia involve risks and the possibility of complications, injury, or death.
- Although uncommon, motor and sensory nerves may be injured during the procedure, resulting in temporary or permanent weakness or loss of facial movements. Motor injuries typically improve over time. Injury to sensory nerves of the face, neck and ear regions may cause temporary or more rarely permanent numbness.
- Discomfort may be experienced during and/or after the treatment.
- Some bruising and/or swelling may occur following the procedure. However, it should resolve in days, weeks, or months.
- Temporary redness (erythema) of the treated area can occur.
- Scarring is rare, but is a possibility if the skin surface is disrupted.
- Although uncommon, burns can occur. And may require additional care at my own expense.
- Infection is rare, but should it occur, treatment with antibiotics and/or surgical intervention may be required. Infection can further increase the risk of scarring. Proper wound care is important in the prevention of infection. If signs of infection such as pain, heat, blisters, or surrounding redness develop, call the office immediately.
- I understand the importance of the pre and post treatment instructions and that the failure to comply with these instructions may increase the possibility of complications.

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_____ I understand that liposuction may be used in conjunction with this treatment, if the physician determines it is necessary to do so. I understand that skin irregularities may occur with any liposuction treatment.

_____ While I understand this technology does not have any manufacturer declared contraindications, it is advised not to treat patients with cardiac devices such as AICD's (auxiliary internal cardiac devices such as defibrillators, mechanical valves, pacemakers).

_____ I consent to having clinical photographs taken before, during and after my procedure. I under stand that these photographs are an important part of my medical record.

_____ In addition, I consent to the use of these photographs, without my identity being revealed, for the education of future patients, professional clinical presentations and medical journals.

_____ The nature and effects of the procedure, the risks, the ramifications, complications, as well as alternative methods of treatment have been fully explained to me by the physician or designated person and I understand them. The benefits of the proposed procedure, along with the probability of success have also been discussed with me. I have been given the opportunity to ask questions and have received satisfactory answers. I certify that I have read the above authorization and that I fully understand it.

_______________________________ Signature of Patient/Date

_______________________________ Signature of Provider / Date

_______________________________ Signature of Witness/Date