**IADVL- Academy**

**SIG (Special Interest Group) Laser and Aesthetics 2018- 2019**

**Consent form for non-contact radiofrequency lipolysis**

(Please acknowledge the source when using this consent form)

Name: Mrs./ Mr. / Ms. ………………………………………………………………………………………………………………….

Address: …………………………………………………………………………………………………………………………………

Hospital ID: ……………………. Phone Number: ……………………………………………………………………………………

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, here by authorize Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ or his trained assistant to operate on myself or on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, who is my \_\_\_\_\_\_\_\_\_\_\_\_\_(relation) for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Initial\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**Treatment Area: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Indications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Machine Used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Non Contact RF lipolysis involves the use of radiofrequency energy of certain wavelengths to heat up the fat cells under the skin on specific areas. This leads to death of theses adipocytes (Fat cells) and absorption of the adipocytes by the body. The procedure requires more than one treatment and may produce some reduction in the bulges and cellulite. The total number of treatments and clinical results may vary between individuals.

Intended benefits are localized fat reduction, improvement of cellulite.

I am aware of the following:

1. The **adverse events like** stinging or burning sensation, redness, swelling, blisters or scabs, infection, scarring, and even risks or complications associated with this treatment that are not yet reported in the literature.
2. The potential benefits of the proposed procedure and possible **alternate procedures** like liposuction, HIFU, Radiofrequency tightening.
3. No **guarantee**, warranty, or assurance has been made to me as to the results that may be obtained and that for maximum and optimum results, several treatment sessions may be required spaced at varying intervals.
4. I understand that **variable results** are seen due to the patients’ lifestyle, medical profile, hormonal status, age, and genetic factors.
5. The need of regularity of treatments, **multiple sessions** or touch-ups and maintenance treatments in the future.
6. The need of proper **pre- and post- treatment care**. (The instructions given should be strictly adhered to).
7. The **cost of treatment** per sitting and the payment schedule. (I will be responsible for reimbursing the cost of the procedure as many of the procedures may not covered by insurance companies or companies).
8. The sensation of the procedure and on occasion, use of topical, block, local or general **anesthesia**. (I give consent for the anesthesia.)

I consent to the **taking of the photographs** during the course of my procedure for the purpose of proper documentation, publications, presentations and post-operative assessment. I give consent for that.

For the **women of childbearing age**: By signing below I indicate that I am not pregnant. Furthermore, I agree to keep the doctors informed should I become pregnant during the course of the treatment.

I will inform the doctor of all current **medications** and change in the medications during the course of treatment.

My **medical history** regarding active skin infection, impaired healing (e.g. keloid scar formers), and pregnancy.

I am giving consent that if anything goes wrong during the procedure, I may be given any **emergency treatment** best suited to me, without asking for my prior permission.

I further state that, I have carefully read and understood all the information provided in this form and with a fully conscious mind, I hereby give my written consent for the said procedure along with its involved risks. **The procedure, the side effects and the risks involved have been explained to me in my native language.** I hereby **release** Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and its designated staff from liability associated with the above procedure.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of the patient/ thumb impression Signature of the Guardian (For Minors)

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Name and relationship with the Guardian Date

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Witness 1 Witness 2