THERMIsmooth® body Consent Form

Patient Name _____ **Date** _____

As a patient, it is important for you to understand the expected results and risks of radiofrequency skin treatment with the Thermi250™ System. Please read this document carefully. Before signing this document, please ask your physician, or the consultant providing the Thermi250 treatment, about any aspect of this document, or the Thermi250 procedure, that you do not understand.

The Thermi250 System equipment may present a hazard to patients with implantable devices, such as, but not limited to pacemakers, defibrillators, cochlear ear implant, or any implantable mechanical device. The Bipolar hand piece may be used with patients that have pacemakers, if device is located somewhere other than the treatment area. Please consult qualified medical personnel prior to being treated with radio frequency equipment if you have an implanted device. I understand that pregnancy is contraindicated and I may be asked to provide a negative pregnancy test. I understand I must be free of any active local or systemic infections.

It is recommended that you avoid treatments directly over areas containing injectable fillers and toxins for one month.

Since ongoing feedback by a patient during a procedure is required, if you have nerve insensitivity to heat anywhere in the treatment area, you should not be treated with the Thermi250 System.

The Thermi250 treatment uses the Thermi250 equipment and is unstudied and unknown for pregnant patients, patients with autoimmune disease, diabetes, or herpes simplex. I understand this document and give my consent to receive treatment with the Thermi250 system.

DURING TREATMENT

You may feel an electric shock similar to a static discharge in a dry environment when the electrode makes contact or is removed from the skin. A common comparison is the static shock you might feel when touching something after dragging your feet across carpeting. Beard stubble should be thoroughly removed prior to treatment as remaining stubble may accentuate shocks. If the eyelids are to be treated directly, a non-conductive eye shield may be placed in your eyes.

All jewelry (including piercings) and makeup, including lotions, eyeliner and eye shadow should be removed from the treatment area prior to treatment.

Cut, wounded or infected skin should not be treated as this could promote infection and injury.

Slight discomfort may be experienced while undergoing treatment. Typically, the discomfort is mild and temporary during the procedure and localized within the treatment area. During the treatment, you should feel warmth and heat and provide ongoing feedback to the individual performing the treatment.

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DURING TREATMENT (CONT.)

Therefore, no anesthetic (local, oral, or systemic) should be used prior to or during the treatment. Additionally, if you have nerve insensitivity to heat anywhere in the treatment area, you should not be treated. Please notify the treatment provider of any discomfort as avoided, inadequate or impaired feedback may lead to burns or injury.

AFTER TREATMENT

There is the possibility that additional risk factors of radiofrequency skin treatments may be discovered. The results of performing Thermi250 treatments in combination with other treatments is unstudied and unknown.

It has been explained to me that this is a cosmetic procedure and not covered by insurance. It has been explained to me that more than one treatment may be recommended to achieve the best results and that there are other treatment options such as microdermabrasion, chemical peels, filler injections, or no treatment at all. As mentioned before, there is no guarantee of results and no refund of payments for the procedure will be made.

My signature below signifies that all of my questions have been answered by the physician or consultant. I understand the risks, complications, expected results, and expense of the treatments. I have read and understand this document and give my consent to receive treatment with the Thermi250 radio frequency system.

Patient Signature _____ Date _____

Patient Name _____

Physician Signature _____ Date _____

Physician Name _____

Witness Signature _____ Date _____

Witness Name _____