IADVL- ACADEMY- SPECIAL INTEREST GROUP- LASERS AND AESTHETICS.

CONSENT FOR CRYOLIPOLYSIS

Mr/Mrs./ Miss_____

Age

Address _____

City_____

Phone _____, _____, Mobile_____

Name of PROCEDURE_____

CRYOLIPOLYSIS System Used: ----------

Areas to be treated:

The purpose of this procedure is to cause localized fat reduction and give body contouringin the areas indicated above. Theprocedure requires more than one treatment and may produce some reduction in the appearanceoffat and improvement in the shape of the area.

The total number of treatments and clinical resultsmayvary between individuals.

Most patients require a number of treatments over several months with gradual results occurring over this time. On occasionthere are patients that do not respond to treatments and so the outcome cannot be guaranteed.

I was also informed about the other alternative methods as well as their benefits and disadvantages. I understand that for ideal results, this procedure can be combined with radiofrequency, surgical options, etc.

No guarantee, warranty, or assurance has been made to me as to the results that may beobtained.

I am also aware that follow-up treatments may be necessary for desired results.

I understand that short-term effects may include reddening, mild burning, temporary bruising ortemporary numbness. These conditions usually resolve within 15-30 days after treatment. Late onset pain is a common side effect seen 2 weeks after procedure. It usually resolves without any intervention.

I agree that any pictures taken of my treatment site may be used for publication or teaching purposes; however my name or identity will not be disclosed and complete confidentiality will be maintained.

By signing below, I acknowledge that I have read the adverse reactions above and I feel that I have been adequately informed of the risks of Cryolipolysistreatment.

Before each treatment, I will inform the doctor if I have taken any new medications since my last treatment.

I also agree to comply with the recommended aftercare instructions.

I hereby release Dr. and its designated staff from liability associated with the above procedure.

My questions regarding the procedure have been answered satisfactorily.

I authorize Dr. and his/her designated staff to perform Cryolipolysistreatment on my body.

The payment and fee structure is informed to me. I am ready to pay per sitting or package basis. [Package if opted for includes minimum number of sittings and I have to pay accordingly if more sittings are required]

SIGNATURE OF PATIENT/THUMB IMPRESSION
SIGNATURE OF PARENTS /GUARDIAN (FOR MINORS)
DATE:

_____
NAME AND RELATIONSHIP IF SIGNED BY OTHER THAN PARENT

WITNESS: DATE:

NAME_____
SIGNATURE_____

DATE: _____

SIGNATURE OF DOCTOR----------DATE----------

TRANSLATED IN PATIENTS LANGUAGE BY----------