

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

CONSENT FOR HI INTENSITY FOCUSED ULTRASOUND (HIFU)

Mr/Mrs./ Miss _____

Age _____

Address _____

City _____

Phone _____, _____, Mobile _____

Name of PROCEDURE _____

HIFU System Used: -----

Areas to be treated:

The purpose of this procedure is to tighten sagging skin in the areas indicated above. The procedure requires more than one treatment and may produce some reduction in the appearance of sagging skin and/or wrinkles.

The total number of treatments and clinical results may vary between individuals.

Most patients require a number of treatments over several months with gradual results occurring over this time. On occasion there 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 be obtained.

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

Alternative methods available such as fillers, botulinum toxin, dermabrasion, chemical peels etc. have been discussed and explained to me.

The following problems may occur with the procedure.

1. Short-term effects may include reddening, mild swelling, mild burning and temporary bruising. These conditions usually resolve within 1-3 months.

2. Rarely temporary numbness of the treated skin may be seen after treatment and will resolve with time (generally days to weeks).
3. Infection: Although infection following treatment is unusual; bacterial, fungal and viral infections can occur. Should any type of skin infection occur, additional treatments might be necessary.

Topical, local or general anesthesia is required in few patients. I am ready to take the appropriate form of anesthesia.

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 Hi Intensity Focused Ultrasound treatment.

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 Hi Intensity Focused Ultrasound treatment 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-----