# CONSENT FORM - BODYFX™

## East Hill Laser & Aesthetics

### Personal Information:

| Name: | Date of Birth: |
|---|---|
| Address: | Employment: |
| Home Telephone: | Cell Phone: |
| Email: | Emergency Contact: |
| Emergency Contact Relationship: | Emergency Contact Phone Number: |

### Health questionnaire:

| Existing or recent illness | Details: |
|---|---|
| Hospitalization / surgery | Details: |
| Medication | Details: |
| Medicine intolerance | Details: |
| Aesthetic procedures in the treatment area | Details: |

**Medical History** – Please inform physician or assistant prior to treatment if you have any of the following conditions that may make you unsuitable for BodyFX™ treatments.

- ☐ Pregnancy or nursing
- ☐ Under 18 years of age
- ☐ Pacemaker or internal defibrillator
- ☐ Permanent implant in the treated area such as metal plates and screws, silicone implants or an injected chemical substance
- ☐ Current or history of cancer, especially skin cancer, or pre-malignant moles
- ☐ Impaired immune system due to immunosuppressive diseases such as AIDS and HIV, or use of immunosuppressive medications
- ☐ Severe concurrent conditions such as cardiac disorders, epilepsy, uncontrolled hypertension, and liver or kidney diseases
- ☐ A history of diseases stimulated by heat, such as recurrent Herpes Simplex in the treatment area
- ☐ Any active condition in the treatment area, such as sores, psoriasis, eczema and rash as well as excessively/freshly tanned skin
- ☐ History of skin disorders such as keloid scarring, abnormal wound healing, as well as very dry and fragile skin
- ☐ Any medical condition that might impair skin healing
- ☐ Poorly controlled endocrine disorders, such as diabetes or thyroid dysfunction
- ☐ Any surgical, invasive, ablative procedure in the treatment area in the last 3 months or before complete healing
- ☐ Use of Isotretinoin (Accutane®) within 6 months prior to treatment

## Specific Informed Consent for BodyFX™ Treatments

This form is designed to give you the information you require to make an informed choice of whether or not to undergo treatment with BodyFX™ technology. If you have any questions before your treatment please feel free to ask.

- I hereby authorize Dr. Hogan/Dr. Sayre and/or such assistants as may be selected to perform the BodyFX™ procedure.
- The physician obtained my medical history and found me eligible for treatment.
- I have received the following information about the technology:
    - BodyFX™ technology is non-invasive and utilizes vacuum to withdraw the tissue into a chamber in the applicator, thus enabling a treatment deeper in the fat layer.
    - The BodyFX™ treatment is based on radiofrequency (RF) at levels that induce heating of the fat cells, stimulating fat metabolism and breakdown, as well as destroying some of the fat cells membranes. All these effects lead to circumference reduction and body contouring, as well as to cellulite improvement.
    - In addition, the RF-induced heat is stimulating collagen regeneration and replenishment for skin tightening.
    - The treatment creates redness and a warm sensation over the skin surface for several hours, as a normal response.
- I understand that taking the treatment course is my choice and that I am free to withdraw at any time, without giving any reason.
- There may be alternative procedures or methods of treatment that cause stimulated fat metabolism, using RF with different number of electrodes, or technologies based on ultrasound or freezing that destroy fat cells. None of them can do both actions, like the BodyFX™. Details were explained to me.
- I was told about the possible side effects of the treatment including: local pain, skin redness (erythema), swelling (edema), damage to the natural skin texture (crust, blister, burn), change of pigmentation (hyper- or hypo-pigmentation), scarring, and vacuum bruising. Although these effects are rare and expected to be temporary, any adverse reaction should be reported immediately.
- I understand that the treatment involves about 8 weekly sessions, and that maintenance sessions may be required periodically, once in a few months, according to individual response.
- I understand that I have to comply with treatment schedule, otherwise results may be compromised.
- I recognize that during the course of the procedure unforeseen conditions may necessitate different procedures than this above and I authorize the physician or assistants to perform such other procedures if they find them professionally desired.
- I understand that not everyone is a candidate for this treatment and results may vary. Therefore, there is no guarantee as to the results that may be obtained.

The procedures to be used to treat my conditions have been explained to me.

Patient Initials: __________ Physician/Assistant Initials: __________

1. I have had sufficient opportunity to discuss my condition and treatment. I believe I have adequate knowledge upon which to base an informed consent.
2. Any questions I may have asked have been answered to my satisfaction.

______________________________ ______________________________

Patient Signature Physician/Assistant Signature

______________________________ ______________________________

Patient Name (Print)
Or person authorized to sign for patient

Physician/Assistant Name (Print)

______________________________

Date